Volume I

NATIONAL HEALTH INSURANCE

MAJOR PROPOSALS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

CONSIDERATION OF THE MAJOR PROPOSALS RELATING
TO NATIONAL HEALTH INSURANCE

DECEMBER 8, 9, AND 10, 1975

Serial No. 94–60

Printed for the use of the
Committee on Interstate and Foreign Commerce

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- American Life Insurance Association:
  - Hemry, Leslie P., president, Health Insurance Association of America.
  - Pettengill, Daniel W., vice president, Aetna Life & Casualty.
  - Rathgerber, Frederick E., executive vice president, Prudential Insurance Company of America.
- American Hospital Association:
  - Hash, Michael M., director, division of legislation.
  - McMahon, John Alexander, president.
- American Medical Association:
  - Parrott, Max H., M.D., president.
  - Peterson, Harry N., director, department of legislation.
- Chamber of Commerce of the United States:
  - Sonnemann, Roger C., member, Board of Directors, and Chairman, Special Committee on the Nation's Health Care Needs.
  - Wooden, Rose P., committee executive, Special Committee on the Nation's Health Care Needs.
- Health Insurance Association of America:
  - Hemry, Leslie P., president, HIAA.
  - Pettengill, Daniel W., vice president, Aetna Life & Casualty.
  - Rathgerber, Frederick E., executive vice president, Prudential Insurance Company of America.
- Health Security Action Council:
  - Fine, Max W., executive secretary.
  - Woodcock, Leonard.
- International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW:
  - Glasser, Melvin A., director, social security department.
  - Woodcock, Leonard.
- Life Insurers Conference:
  - Hemry, Leslie P., president, Health Insurance Association of America.
  - Pettengill, Daniel W., vice president, Aetna Life & Casualty.
  - Rathgerber, Frederick E., executive vice president, Prudential Insurance Co. of America.

NATIONAL HEALTH INSURANCE

Major Proposals

MONDAY, DECEMBER 8, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. Rogers. The subcommittee will come to order, please.

Today the Subcommittee on Health and the Environment begins its consideration of national health insurance—a concept which was articulated more than 25 years ago by President Truman and one which, as health care costs spiral and as more and more gaps in health care coverage are identified, has far-ranging implications for every segment of our society.

Over the past several years, this subcommittee has examined the components of the American health care system and has developed legislation to encourage the planning and development of health resources, to increase and redistribute our supply of health manpower, and to support the development of organizational choices in the health care delivery system. We have supported stop-gap measures such as migrant health centers, neighborhood health centers, and mental health centers to provide needed health services where either geography or lack of financial resources discourage the provision of such services. We have laid the foundation for a responsible national health care program.

The subcommittee must now turn its attention to the development of a national health insurance plan.

We are meeting at a time when the costs of health care delivery are growing faster than our economy and the number of Americans with adequate health care coverage is shrinking. The costs of both our public and private health insurance programs are increasing at an alarming rate and the proportion of our gross national product spent for health care—8.3 percent—is far greater than that of any other country.

At the same time that this country is spending nearly $120 billion each year—or about $547 per person per year for health care—approximately 25 million Americans have no health care coverage, public or private. The limitations of the medicaid program which make it available only to certain groups of the poor—the aged, the blind and disabled, and families with dependent children—and the prohibitive costs of private health insurance coverage, leave a significant portion of our population—the working poor, those who have lost jobs and hence, their health insurance coverage—without adequate health care protection. Moreover, many States are finding it necessary to reduce medicaid eligibility and program benefits.

Medicare is paying for an increasingly smaller portion of the health care costs of the elderly. The $16 billion which the Federal Government will spend to support the medicare program now pays for only 40 percent of the health care costs of our elderly.

Moreover, private health insurance has not insured adequate health care coverage. As many as 50 percent of the privately insured do not have coverage for catastrophic illness. Many people find that their private health insurance policies do not pay for preventive care or even for outpatient care.

This subcommittee has developed the foundation on which to base a responsible national program. We must now look to ways to assure access to adequate health care for all Americans. We intend to structure our hearings, not to develop a record of words or to schedule the greatest number of witnesses ever heard by a congressional committee, but rather to develop the specific information on the hard and critical choices that not only must be made initially by this subcommittee but those which must eventually be made by the Congress and the American people.

To begin our hearings we have invited proponents of the various national health insurance proposals to present their views to the subcommittee. While we expect to hear honest differences of opinion concerning the approach we should take to improve health care coverage, it is impressive that all of these witnesses realize that change is needed and have developed or sponsored legislation to establish a national health insurance program. We welcome their testimony and look forward to working with each of them—and those witnesses who will appear before the subcommittee in the months to come—to develop legislation which can be enacted by this Congress. We also look forward to working together with the Health Subcommittee of the Ways and Means Committee, and with the administration, on this issue of critical national importance.

There may be other statements that members would like to make before we call our first witness.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. I just have a few words I want to say.

Mr. ROGERS. All right.

Mr. CARTER. In the first place, admittedly we do have problems with our present health delivery system. As a delegate to the Republican Convention in 1972, through my efforts renal dialysis became part of the program of the platform of that party at that time. Dislexia also became a part of the platform of that committee.

It was necessary in these cases to take this to the White House from Miaimi before it could be approved.

One other plank in that platform was the coverage of catastrophic illnesses. This was a plank which I advocated and which became part of that platform.

I think that it is very necessary that catastrophic illnesses be covered one way or another because a family which is beset by a serious accident or a catastrophic illness simply cannot see its substance wasted way in caring for an unfortunate member of that family. Personally, I feel that some effort must be made in this direction.

I should like very much to see, regardless of what other good friends may have in this area, this become enacted into law. I feel that is necessary. Piecemeal as it may be, as we all know, our economy is in a rather difficult state at this time. We can see from the situation in great cities like New York and others that financing is difficult to come by. While programs advanced by certain groups might well be advantageous, they may not be within the realm of possibility economically.

Therefore, Mr. Chairman, I certainly support the addition to the present program of care for those who are catastrophically ill. At a later date I shall also advance for your consideration and that of the committee, a national health insurance bill as an alternative which has with it a preventive medicine program which I think is extremely important.

Mr. Chairman, I shall listen with interest to the distinguished gentleman who will speak to us today.

Mr. Rogers. Thank you very much.

Mr. Scheuer, do you have comments?

Mr. Scheuer. I will yield to Mr. Preyer.

Mr. Rogers. Mr. Preyer.

Mr. Preyer. Well, I am delighted, Mr. Chairman, we are beginning these hearings and I will be interested in sparring with these witnesses as to the how and the why of national health insurance. I commend you for proceeding with the hearings.

Mr. Rogers. Mr. Scheuer.

Mr. Scheuer. Thank you, Mr. Chairman.

May I say that I am particularly pleased to be here today at the outset of these hearings because I am a freshman member of this committee, and I am very interested in learning the answers to some important questions that I think all of use have to be thinking about: where the gaps are in our present coverage; where the benefits are for the inpatients, for the outpatients, for those with home health care; how we finance a national health program, whether through general revenue, through the payroll tax, or through the private insurance industry, who runs the program. Is it the Federal Government, the States, the private sector? What kind of peer review process do we have to insure quality control of the delivery of health services? What other means are there to assure quality control, reimbursement for hospitals, for physicians?

I do not have to describe to you, Mr. Chairman, the problems of hospitals providing ambulatory service, outpatient clinics, and so forth. They are absolutely desperate. Who is going to provide oversight for the system? Who is accountable to whom in the operation of the program? How will a national program interface with our present medicaid and medicare programs, the VA system, and so forth? How will we better control the use of drugs both as to cost and as to effectiveness? How do we meet the program you described, Mr. Chairman, of preventive care and outpatient care, which are being badly provided and underfinanced? In terms of cost-effectiveness, these must be the keystones of any national health program. We cannot create a funding mechanism for national health insurance without a determined effort to control costs; otherwise the costs will soar into the stratosphere. Lastly, Mr. Chairman, what can this committee and this Congress do about the problem of human behavior? Once we have a minimum infrastructure of health services, by far the most important element in health outcomes is not a further elaboration of services, but the way we use the existing infrastructure of services and the way we govern and control our own lives. This includes what we ourselves do about diet and exercise, about tobacco, alcohol, and drugs, and about violence in our own lives—for which we seem to have a very troublesome proclivity—preventable violence and death, through the automobile and between people.

These are some of the subjects on which I hope the witnesses will enlighten us. Again, I consider it a privilege to be involved in these hearings.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. And first, I would like to congratulate you upon your effort in calling this subcommittee to consider what certainly is one of the most important subjects in the country today. I have some serious problems in my own mind as which directions in fact this Congress and the country should proceed toward development of what I deem the demand side of the delivery of the health care system.

I think the questions that have been raised here already by the members pointed out that in fact this Congress and this country does not have and has not articulated a firm policy on how we ought to, both in the private and public sector, proceed toward development of a national health policy.

I tend to describe a national health policy, which I believe we lack, as a mechanism which would determine and articulate very broad goals and specific priorities that would form a blueprint for a national health system; and national health policy should also be set to rationalize the current fragmentary approach to health policy development in organization, delivery and financing of personal health care services in both the public and the private sectors.

I think that this country should certainly first, before we do anything relating to additional demands on the existing system, make a determination as to in fact where we should go in the question of national health policy.

I think, Mr. Chairman, that it makes no sense to proceed to take a look at health care financing and health care resources separately. I think it is absolutely imperative that this country keep in mind as we try to develop our resources that we tie to those considerations the question of financing.

For that reason, this committee, Mr. Chairman, over the years and most recently, has developed a National Health Resources Planning Act. We are just in the very infancy of implementation and nothing more in allocation of the national resources. Yet it is absolutely essential. The question of health manpower must be resolved. The question of quality, has been raised by the question of medical malpractice and PSRO's. Those are the supply sides of the equation. These are questions I believe, that this Congress and the country indeed, is going to have to consider, bearing in mind what you yourself stated in your opening statement, Mr. Chairman, about a system that takes 8.3 percent of the Gross National Product of this country, now $118.5 billion, the second largest industry in the United States of America, and yet we have not been able to put together that equation of supply and demand, we have not, in fact, this Congress has not been able to decide whether or not we should proceed to look at resources and financing in the same breath, and I suggest, Mr. Chairman, that it is absolutely imperative that we move in that direction and that we have firmly in mind what our health care system should be before we impose the additional demand that certainly would be required under any system of national health insurance.

I, too, will hopefully participate to the best of my ability, Mr. Chairman, to try for the country and the Congress to produce a system of national health care that in fact will reflect the needs of the country to the best of our ability, and I thank you very much for calling these hearings, Mr. Chairman.

Mr. Rogers. Any other statements?

Mr. Heinz?

Mr. Heinz. Mr. Chairman, my statement is brief. I am delighted that this committee, which has been so deeply involved for many years under your chairmanship, in questions of health manpower, resources, Hill-Burton, rewrite of the entire Public Health Service Act—as we did last year—community mental health centers, other health services, and the question of health revenue-sharing, will now turn itself to careful consideration of a system of national health care. This committee has developed a depth of understanding and a breath of expertise that can be put to very good use as we listen to the witnesses the committee has called, as we evaluate the various proposals for national health insurance that are going to come before this committee, and as we try to take the best of those proposals and fashion from them a health care system. We will try to the best of our ability to match human needs which the resources that we have or can develop to make sure that the health care system in this country is second to none.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you.

Without objection, the Chair wishes to place in the record, as though read, a statement submitted by Congressman James C. Corman of California.

STATEMENT OF HON. JAMES C. CORMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Corman. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to describe briefly the importance of action on comprehensive national health insurance and the approach of the health security program for addressing the Nation's health care needs. The subcommittee's thorough examination of this issue will greatly facilitate the development of a successful national health policy.

The Health Security Act is strongly recommended for your consideration as the most realistic and effective response to the health needs and concerns of the American people. I have introduced H.R. 21[1] with 100 cosponsors and Senator Edward Kennedy has introduced S. 3 with 19 cosponsors.

The national health insurance debate has been sidetracked far too long by the sham argument about cost. Instead of a serious and forth-right discussion about the merits of the various legislative proposals, the American people have suffered the dishonesty of a range of counterfeit cost estimates.

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[1] See p. 475 for full text of H.R. 21.

These hearings will be landmark if they result in exposing the myths about the cost of national health care.

The issue is not what proposals are "less expensive" than others because the consumer knows who pays the final bill. The important point is that we are now spending more than $118 billion for health care and that amount is soaring. Thus, the primary issue is whether the stark economics of health care are allowed to go unchecked or whether responsible public policy decisions will be made to reform the health care delivery system.

National health insurance is not needed, in the form of health security or any other program, because we as families or a Nation need to spend more money to obtain necessary health services. We spend more per capita and use more of the Nation's resources for health purposes than any other Nation in the world.

Support for comprehensive national health insurance arises out of the increasing need to spend our health care dollars more effectively and efficiently. The rapid and uncontrollable increases in medical costs under the existing methods of receiving and paying for care have become too burdensome.

The litany of facts and figures about the rising health expenditures need not be repeated. In short, medical costs have outstripped general economic growth as well as workers' wages. In addition, the impact of recession, notably continued high unemployment, worsens the economic realities of health care.

The design of the Health Security Act is to improve and protect health, while maintaining health expenditures within reasonable limits. Initially, as all Americans obtain access to needed care under health security, some increase in expenditures can be expected.

Health security is the only health program that, in the long run, promises to provide realistic mechanisms for effectively containing and directing health expenditures. Through the national and regional budgeting process that requires hospitals to budget their costs and doctors to stick to established fees, increases in health expenditures will be kept within reasonable limits and directed to meet changing health needs. By encouraging prepaid health programs, preventive medicine, early diagnosis and office or outpatient treatment, it will substantially improve the quality of health care and result in a health system that will cost less than if present arrangements are allowed to continue.

The cost containment advantages of health security are displayed in the most up-to-date estimates of total cost for the health security program and other major proposals. I have included these cost calculations, provided by the Committee for National Health Insurance, as an appendix to this statement.

The Kennedy-Corman Health Security Act reflects two fundamental objectives. The first is that every American should be assured access to appropriate health care. To eliminate income, residence, employment status, and age as barriers to health services, health security will establish uniform and comprehensive benefits without the usual insurance exclusions or insurance premiums, deductibles, and copayments.

The second precept is that a national health program must go beyond insuring health care to the more difficult, but central, problems of securing health care. In other words, a national health insurance program must introduce improvements in the organization, availability and quality of services.

If there is disagreement about the need to respect adequate health care as an American right, many difficult questions arise. Will there be different ways of paying medical bills for different categories of people? What about different benefits for the various types of care? And are we going to monitor individual's income as well as deductibles and coinsurance payments?

Any time these factors are included in a benefit structure, the program becomes extremely complex and wasteful. The cost of administering a basic means test alone has been estimated to be $2 to $3 billion a year.

It has been argued that a system that does not impose deductibles and coinsurance, requiring individuals to pay first-dollar cost out-of-pocket at the time they seek medical care, will result in high rates of unnecessary use of health resources. There is no evidence that this would happen, and in Canada the evidence is to the contrary. Slight increases in utilization occurred under Canada's health system when deductibles were removed, but these soon leveled off. Canada's experience clearly demonstrates that the paperwork and costs of administering deductibles results in more waste than savings.

Under health security, people will pay for comprehensive services when they are well and working, not at the time of illness. A full range of preventive, routine, and catastrrophic health services will be available when they are needed, not when they can be afforded. The total health costs will be distributed through the equitable and proven social insurance with employers-employees and the Federal Government splitting the cost. As a result, a family's health costs will be predictable and easily budgeted.

Health security will actively encourage more efficient organization and equal distribution of existing health manpower and provide funds for special training of health professionals and allied personnel. A resources development fund would be established to support innovative health programs, particularly in manpower, education, training, and group practice development.

Financial, professional, and other incentives will be built into health security to move the health care delivery system toward organized arrangements for patient care, such as health maintenance organizations and other prepaid group practice plans, and to stimulate the movement of health manpower into medically deprived areas. It will also establish programs for preventive care, early diagnosis of illness, and medical rehabilitation.

The subcommittee is to be commended for the thoughtful manner in which this important issue is being addressed. The public demand for an improved system of delivering and paying for comprehensive health services is mounting. With medical costs soaring, unnecessary delays in enacting health security will speed the erosion of our health care dollar.

Thank you again, Mr. Chairman, for the pleasure of contributing to your deliberations.

APPENDIX

COMPARATIVE COSTS OF NATIONAL HEALTH INSURANCE PROGRAMS—TOTAL NATIONAL EXPENDITURES FOR COVERED PERSONAL HEALTH SERVICES FOR FISCAL YEAR 1978 AND 1982 (ASSUMING PROGRAMS IN FULL OPERATION)

[in billions of dollars]

	No programs	S.3/H.R. 21	Administration	Catastrophic
FISCAL YEAR 1978				
Total expenditures	$142.3	$160.2	$151.1	$148.3
Through Federal budget	38.7	137.3	53.2	46.4
Social security funds	21.3	62.8	29.5	22.5
General revenues	17.4	74.5	23.7	23.9
hrough State/local budget	15.5	4.5	14.1	15.4
Through insurance industry	44.8	4.2	51.5	46.4
Out-of-pocket	41.6	13.6	31.3	38.9
Other	1.7	.6	1.0	1.2
FISCAL YEAR 1982				
Total expenditures	222.0	210.4	235.9	231.4
Through Federal budget	60.4	180.4	83.0	72.3
Social security funds	33.3	82.6	46.0	35.0
General revenues	27.1	97.8	37.0	37.3
Through State/local budget	24.2	5.9	21.9	24.1
Through insurance industry	69.9	5.5	80.5	72.5
Out-of-pocket	64.8	17.9	48.8	60.6
Other	2.7	.7	1.7	1.9
Fiscal year 1982 cost savings (cost increases) measured against "no program" resulting from cost-containment mechanisms in each program:				
Mechanisms:				
Hospital cost controls		14.8	(7.5)	(5.1)
Physician/dentist cost controls		3.3	(3.3)	(2.1)
Other services		(6.5)	(3.1)	(2.2)
Total savings		11.6	(13.9)	(9.4)

NOTES

1. The primary source for these figures is table 2 from Estimated Health Expenditures Under National Health Insurance Bills, a Report to the Congress, July, 1974. See p. 4. These estimates were projected to fiscal year 1978 and 1982 using the following inflation factors: Percent per annum: Hospital costs—15; doctors and dentists—10; drugs and drug sundries—5; other services—8. However, it was assumed that the cost controls in S. 3/H.R. 21 would be effective to reduce costs under that bill from fiscal year 1978 (when first effective to reduce costs under these assumptions) to fiscal year 1982 as follows: Percent per annum: Hospital costs—8; doctors and dentists—5; other—5.

2. Induced costs included in the HEW study were distributed among the various categories of services in each of the programs in proportion to expenditures found in table 2 for fiscal year 1975. Total column. Thus, the projected costs include induced costs.

3. The projected costs were then distributed by source of financing, using the percentage distribution found in table 3 of the HEW study. No effort was made to adjust the projected figures to reflect the likelihood that, because hospital costs are more heavily insured than other health care expenditures, the percentage distribution would changesome what over the years under the assumed inflation factors.

Mr. ROGERS. Our first witness this morning is Mr. Leonard Woodcock, a distinguished American, who will be testifying on behalf of the Health Security Action Council and the International Union, United Automobile, Aerospace, and Agricultural Implement Workers of America.

Mr. Woodcock, we welcome you to the subcommittee, you and your associates. I understand you will be accompanied by Mr. Melvin Glasser, who is director of the United Automobile Workers Social Security Department, and Mr. Max Fine, who is executive secretary, Health Security Action Council.

We are delighted to have you here and we will be pleased to receive your statement.

STATEMENT OF LEONARD WOODCOCK ON BEHALF OF THE HEALTH SECURITY ACTION COUNCIL AND THE INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW, ACCOMPANIED BY MELVIN A. GLASSER, DIRECTOR, UAW SOCIAL SECURITY DEPARTMENT, AND MAX W. FINE, EXECUTIVE SECRETARY, HEALTH SECURITY ACTION COUNCIL

Mr. Woodcock. Mr. Chairman, members of the Health Subcommittee. My name is Leonard Woodcock and I am pleased to appear before you, with my colleagues, in support of the health security bill. I am here today representing 5 million members of the United Auto Workers and their families, and the 80 national organizations which comprise the Health Security Action Council. The members of these organizations number in the tens of millions and represent a broad crosssection of Ameircan life.

With me are Melvin A. Glasser, director of the UAW's Social Security Department and a member of the technical committee of the Committee for National Health Insurance; and Max W. Fine, executive secretary, Health Security Action Council.

Mr. Chairman, we are here to tell you why we support H.R. 21,[1] the Health Security Act, and to offer our assistance in your consideration of national health insurance leigslation. We believe we have considerable expertise as well as conviction to offer since we have been actively studying the relationship of the financing of health care services with its organization, delivery and resources, since the establishment of the Committee for National Health Insurance 7 years ago.

As you begin these hearings, we urge you to keep the consumer interest at the top of your list of considerations. A system which disdains the consumer can never be good for our country. Certainly, those who will be directly affected by any legislation that is passed here must be fully heard—and who is more directly affected by health legislation than those who receive and pay for the personal health services?

Providers no doubt will be herd, including those whose dogmas have produced medical miseries for millions falling outside the system of means tests, work earnings tests, assets tests or similar qualifying factors not related to the need for medical care.

We believe, as we know you do, Mr. Chairman, that in order to make health care services available and accessible to all, higher national priorities must be established for health, and basic reforms must be created in the health care system. Through the leadership of this subcommittee, the Congress already has framed important structural elements in the system. The planning legislation, support for Health Maintenance Organizations, past and pending manpower legislation, PSRO's, community mental health centers and other girders have been placed into the infrastructure. Those who call for incremental steps toward national health insurance fail to recognize that the types of incremental steps which have already been taken, and are being taken through the leadership of this subcommittee, represent practical forward movement in contrast to ill-conceived incremental financing proposals such as catastrophic illness insurance which would stifle opportunities for effective changes in the organization and delivery of services.

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[1] See p. 475 for full text of H.R. 21.

To our mind it makes sense to continue to build the infrastructure for a new national health insurance plan, as you are helping to do, rather than to divert resources to another piecemeal financing arrangement which will actually retard progress and exacerbate the problems of high costs and low productivity in the health care system.

But I should also point out that earlier this year when we appeared before this committee and other committees of the Congress to support legislation to continue health insurance coverage for the unemployed, we were asked why we supported such partial and basically inadequate legislation. We indicated then, as we do now, that unless the Congress faces this problem head on and adopts a comprehensive solution, it will be necessary again and again to face partial, more costly and increasingly unsatisfactory solutions.

Mr. Chairman, the polls show a majority of Americans back national health insurance. They are dissatisfied with the present system. They are even willing to pay more taxes for a national health plan. One-fifth of them are so dissatisfied with the present system that they would have the Federal Government take over the hospitals and nationalize the entire system, putting physicians on salaries. As you know, at this time there is no bill before the Congress reflecting the viewpoints of that one-fifth of the American people, but unless the Congress acts reasonably soon on a health security-type program, the expense and payoff of the present system may leave you with the Hobson's choice of a complete Federal takeover of the system.

CONSIDER COSTS

When the Committee for National Health Insurance was organized in 1968, Federal, State and local governments spent $20 billion for health purposes. Last year, costs of the same services escalated to $41 billion.

Two years from now, the governmental budgets will be emptied of over $55 billion for health care unless changes are made in the system.

It is, therefore, not a question as to whether the Congress should delay action on the issue of health care. The crisis has moved to such a stage that you will have no choice but to provide for an inordinate number of additional billions of dollars or say to the elderly and the poor, "We'll have to take back what we've given you."

Consider private costs as well.

Total costs, private and public, were $118.5 billion last fiscal year and consumed 8.3 percent of our gross national product. This compared with $54 billion and 6.5 percent of GNP in 1968.

Mr. Chairman, last year we spent almost as much per person for health care as we did for all State and local taxes.

Based on present trends we will spend more for health care in only 2 more years. According to the Census Bureau and the Commerce Clearinghouse, all state and local taxes—including income taxes, property taxes, sales taxes, gasoline taxes and all of those nuisance taxes—amounted to $618 per person in fiscal year 1975.

Health care costs per capita were lower, but not by much; $547. However, health care costs rose by 13.9 percent over the previous year while all State and local taxes increased at about half that rate. Health costs are continuing to escalate much faster than other costs in the current fiscal year.

Based on current trends, State and local taxes will edge over $700 per capita in fiscal year 1977, while health care costs also will reach that level.

THE AMA BILL

The problems within the health care system of runaway costs, disorganized services, lack of adequate quality controls, wasteful and inefficient practices and lack of public accountability are now generally diagnosed. In order to provide effective treatment, it is clear to this committee, I am certain, that each of the causes must be dealt with, and dealt with concurrently.

Unfortunately, all but one of the major bills before your committee, Mr. Chairman, choose to ignore most of the problems and thereby would make them worse.

An example is the plan developed by the American Medical Association, which resembles the previous Nixon and Ford plans. While it is generally agreed today that every American should have health insurance coverage, the AMA insists that coverage must be voluntary and not universal—or as they call it. "compulsory."

This bill (H.R. 6222 [1]) asks you to pass a law to mandate employers to offer second-rate private health insurance policies, purchased from carriers of the employers' choice, to all employees. However, the employee could be required to pay 35 percent of the premium costs. The marginally employed and the low-income employed would be reluctant to pay about $350 a year for their shares of the insurance. Many could not afford it. Others would not want it after they examined the policy and found that they and their families would still be liable for up to $2,000 per year in coinsurance payments, or up to $1,500 if they were single. Many services would be limited, others excluded entirely.

The AMA bill is typical of others which would mandate employer-employee insurance. These bills provide for the most inequitable financing of services. An employee earning $6,000 per annum would pay as much as an executive earning $60,000.

Since the AMA bill is totallly lacking in cost controls, even greater escalation of medical costs than at present would occur should this approach be enacted.

Since quality controls would be absent and more dollars present, even greater incentives would be provided for overutilization, overprescribing and unnecessary surgery.

No incentives or supports are provided for EMO's.

Mr. Chairman, we believe that the large majority of physicians are dedicated, hard-working, competent and concerned individuals. Our quarrel is not with our doctors. Our quarrel is with a system which corrupts its own members and fails to meet the needs of the people—with a system which produces too few of the right kinds of doctors, rewards inefficiency and ineffectiveness, leaves millions unserved in rural America and the inner cities and forces consumers to pay astronomical amounts for espisodic care. The AMA bill would not remove patient frustrations which plague the doctor-patient relationship.

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[1] See p. 927 for full text of H.R. 6222.

It would only extract higher fees from patients and make solo practice, fee-for-service even more rewarding for doctors than at present. Health care would for the foreseeable future be locked into this corrupting system which lies at the root of many malpractice actions. Abuses would be ignored.

In the health security bill (H.R. 21) which we support, provision is made to continue the fee-for-service system, but to introduce essentially needed controls on the cost and quality of the services delivered under this system.

LONG-RIBICOFF BILL

Those who believe that progress must be made incrementally regard the Long-Ribicoff catastrophic insurance plan as an acceptable response to the health care crisis. We believe, however, that this bill has serious and even fatal flaws.

While the bill lacks any provision for representation of the consumer, it is clear that it would greatly strengthen the position of the private insurance companies.

A $30 billion industry which has failed to provide universal coverage, failed to control medical costs, failed to assure quality and which has enjoyed great success to date in defeating real national health insurance proposals would be further enriched by the Long-Ribicoff bill.

By law, the major share of the estimated $8.9 billion additional first-year costs of the program would flow through the insurance industry, which already retains $4 billion for its operating expenses and profits ineffectually administering current health insurance plans.

Mr. Chairman, catastrophic health insurance will not help people because it is based on a myth. The myth is that people already have good basic coverage but require protection only against catastrophic illness. The reality is that people do not have good basic coverage. Some do, most do not. In its "Forward plan for health," even the administration concedes this point, as follows:

> The fact that most of the insured population has inadequate benefits is * * * troublesome. Most basic insurance policies exclude preventive care services, ambulatory care, and prescription drugs and medical devices, and many policies still exclude preexisting conditions and congenital defects. In addition, many policies include only limited coverage of other necessary services, such as mental health care. The usual protection against medical and financial catastrophes is also inadequate.

In other words, catastrophic insurance would be like building an archway with no foundation. Most people would be wiped out long before the trigger point for any benefits. Mostly the rich would benefit—rich providers, rich insurance executives, and rich patients. Working people would pay the bills.

Catastrophic health insurance has deductibles of 60 hospital days and $2,000 in physician fees and medical expenses. This is a bill with a deductible of $11,500.

Catastrophic health insurance will not provide any benefits at all to 99.5 percent of the American people, but it sounds good.

Mr. Chairman, there are other important reasons why we would oppose catastrophic health insurance as an alternative to comprehensive health insurance.

It would create greater imbalance and inflation in the health care system by adding to incentives for very expensive care and disincentives for preventive care.

It would distract the Congress and the public from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems were being dealt with by providing coverage for catastrophic expenses.

It would invite providers of services to raise prices, especially for the seriously ill and dying, on the excuse that the family or individual would thereby become eligible for catastrophic benefits. The net result would be a price rise in all aspects of health care.

It would create incentives for longer hospitalization and other institutional care. There would be tremendous pressure to keep the patient in the hospital until the trigger point for catastrophic was reached.

It would weaken efforts to institute quality controls since catastrophic coverage would not take effect until after the 60th day of hospitalization—and consequently, any controls written into the bill could not be instituted until after the 60th day of hospitalization.

Because of the high deductibles and the overwhelming emphasis on major illness, it would further distort the allocation of national health care resources, turning them further away from health maintenance, early diagnosis of disease, home health care, and other neglected aspects of the system.

It would strengthen the hand of the commercial insurance companies vis-a-vis national health insurance.

It would aggravate the maldistribution of services caused by economic factors since the major beneficiaries of catastrophic coverage would be those who are able to spend the deductible amounts.

It would further skew manpower away from rural and smalltown areas by increasing the funds available to pay lucrative specialists in the urban areas.

It would increase the cost of medicaid and medicare and other governmental programs. (By pouring more money into the private sector, simultaneous accelerations of costs of public programs would occur.)

It would increase the fragmentation and complexities of the financing system.

Any encouragement to a "catastrophic only" health plan by this Health Subcommittee would, in our opinion, ill serve the heads of the American people.

ADMINISTRATION POSITION

Mr. Chairman, since you must deal directly with the administration and its alleged policies in health, you may understand them, but I must confess that we find them incomprehensible.

In the last year, while a moratorium on spending was imposed by the administration, millions of American families played Russian roulette with the lives and health of their children—a year in which 5.3 million of our 13.2 million preschool children were unprotected against the killing and crippling infectious diseases: Polio, measles, rubella, diphtheria, whooping cough, and tetanus.

While any administration plans for national health insurance were locked away, in the White House, one-third of all pregnant women who delivered in public hospitals had no prenatal care and consequently, ran high and unnecessary risks to themselves and their babies.

It is instructive to compare this with Canada. In 1968, the first year they adopted comprehensive national health insurance, their infant mortality rate was 5 percent lower than ours. In 1973, the Canadian rate was 14 percent lower than that of the United States.

While millions of America's laidoff workers joined both the lines at the unemployment office and the swollen ranks of 40 million Americans who face disaster in the event of even a short acute illness or injury because they have no health insurance at all, the administration offered no alternatives, or even excuses—only opposition to helping them.

Doctor strikes, public hospital overcrowding, priviate hospital and nursing home profiteering, and scandalous abuse of the weakest and least able of our senior citizens, are all of seeming unconcern to this administration.

But we have not abandoned all hope. We await the introduction of their proposals for national health insurance in the hope and expectation that they have a contribution to make to this debate and to the cause of decent health care for all Americans.

HEALTH SECURITY

Mr. Chairman, we are convinced as are a majority of the American people, that our Nation needs a universal, comprehensive national health insurance program. This country is one of the two or three top spenders on health care in the world. Yet, the United States is the only industrialized Nation in the world that does not have a national health program for its people.

We do not need to spend more money; we are already spending too much. And we know from direct experience in our own union that the cost problem is getting worse and worse. Our employers are letting us know it. So are our members. And the unfortunate fact is that there is relatively little we can do about this situation. It requires comprehensive Federal action.

As a nation we face the same cost trauma with regard to the urgently needed medicare and medicaid programs. The OMB estimates that costs which totaled $10 billion in 1970, will increase to $25 billion in fiscal year 1976 and total $52 billion in fiscal year 1981.

Unless this committee and this Congress act affirmatively and comprehensively about the health care system, there is no escaping the fact that the Congress will have to provide $27 billion more 5 years from now for the same inadequate health programs we have today.

But it would be wrong to look only at the dollar sign in terms of health care. It would be wrong to emphasize only that this country spends far more per capital on health care than any other nation in the world and that by most of the accepted indices of health studies, we lag behind almost every other industrialized or sem-industrialized nation.

We need to look at the quality of the care we are getting. We need to ask ourselves whether the many studies and reports of needless surgery should produce action programs to correct the situation.

We should be deeply disturbed by the large numbers of us who end up in hospitals each year as a result of reactions to prescribed drugs—some estimates indicating that as many as 80 percent of these reactions could have been avoided. We need to worry when we are told that as many as 30 percent of all the X-rays taken are either inaccurate or unreadable. We should be demanding far more aggressive measures to see to it that the large numbers of inaccurate or even wrong findings of laboratory tests are reduced sharply and possibly eliminated entirely. How on earth can we expect to get adequate treatment from the health care system if it is based on faulty tests?

In the interests of "economy," those who would do nothing advocate the incremental or step approach. They acknowledge the problems in health care to which I allude. But they say, "Let's try to get them fixed one by one. We should not try to do it all at once."

Mr. Chairman, creeping incrementalism will not shore up our collapsing health care delivery system. A complete breakdown would be the more likely result of adding catastrophic insurance and other incremental patches to the medicare and medicaid models.

If we enact a national health plan which will generate real reforms, we can preserve the best in our present system and replace its worst features. If we add patches, the whole system may go under in a few years.

Those who favor incrementalism, completely abandon cost and quality controls, and systems improvements. Unless these are built into any plan, the plan will do nothing but exacerbate the problems it is trying to correct.

Incrementalism has been the approach which we have followed in the United States in the last 30 years. It is precisely this approach which has led us to the sad state of affairs in health today. The health security program through seeing all of the problems in relation to each other, and through using the leverage of large funds coming into the system, proposes to begin to integrate the necessary corrective measures in restructuring the system. It is admittedly evolutionary and it will take time to produce progressive change. But it sees the problem as a whole and deals with it in like manner.

Delivering health care to every American depends on the development and organization of the available resources, and an equitable financing system. It depends on the leverage and support of a national health insurance plan which will create the resources and provide the leverage needed for reforms. Health security alone meets these standards.

Many national organizations—religious groups, labor, senior citizens, health professionals and others—have endorsed the principles of the Health Security Act as essential to the legislation you are considering. The first of these principles is health care as a right, unabridged by any means tests, work earnings tests or any other requirements. No greater observance of the Nation's Bicentennial could be imagined than the enactment of a law which will make real the principle that every American has a right to health care.

We believe that the legislation enacted must:

Provide universal coverage, under one system.

Provide for comprehensive health care services, including preventive care as well as diagnosis, treatment and rehabilitation.

Provide payment in full for all costs of covered services, including the extraordinary costs of catastrophic illness.

Finance all covered services through a trust fund based on payroll taxes and general revenues, administered by the Federal Government.

Contain strong quality control mechanisms.

Establish prospective reimbursement of providers to control costs, eliminate duplication and reduce waste.

Assure effective consumer participation and public accountability.

Provide resources, development and distribution in a system responsive to community needs.

Of the bills before your subcommittee, only the Health Security Act measures up to these essential principles.

CAN WE AFFORD HEALTH SECURITY

The question of costs was well answered by Dr. Rashi Fein, professor of economics at Harvard Medical School.

> New parks, roads or bombers represent money for things the people would otherwise not have. But medical care is different; we are already spending $104 billion, and private expenditures account for $63 billion of that total.
>
> So the issue is a non-issue. The question, can we, as a people, afford national health insurance, really means can we afford to spend what we are already spending—and surely the answer is, "yes".

Understandably, this subcommittee as the Congress, is concerned about costs to the Federal budget, as well as costs to State and local governments, and to the family budgets.

Our consulting actuary has prepared an analysis of comparative costs of national health insurance programs for future years. Using the methodology developed by the administration, including some assumptions with which we would not necessarily agree, the analysis shows nevertheless that H.R. 21 would, within four years, actually save $21 billion annually in national health expenditures in comparison with the catastrophic insurance program. It would save $25.5 billion in comparison with the administration's own CHIP plan, which served as the blueprint for the new AMA bill. And it would save $11.6 billion in costs which would otherwise occur as a result of doing nothing.

The reasons for the savings are not complex. Under the Health Security bill, all costs would be anchored to budgets prepared and approved in advance. Under H.R. 21 system reorganization would be encouraged, with the concomitant savings in hospital utilization and provider costs which result from the team approach to the delivery of comprehensive benefits. Under other bills, payments to providers would remain open ended.

We would like to submit this analysis for the record. It is the appendix [see p. 19].

Mr. Rogers. Without objection.

Mr. Woodcock. Eventually, all health care must be paid for by the people, either through taxes, premiums to private companies, deductibles, or co-pay. The real test of a national health insurance program is how it spreads the risks and encourages access to health services.

THE BUREAUCRATIC MYTH

Mr. Chairman, we feel the evidence is clear both in our own social security program and in the Canadian national health insurance program that administrative costs of national health insurance would be reduced by a health security-type program in comparison with the present system of hundreds of insurance companies, each with its own sales force, claims department, reserves, profits and battalions of underwriters and clerks.

Mr. Weinberger, the former Secretary of HEW, testified before the Ways and Means Committee last year that 45,000 to 49,000 additional empolyees would be required to administer H.R. 21. However, the chairman of the board of the Equitable Life Assurance Society of the United States has stated that 300,000 private health insurance employees would be put out of work if the Health Security Act were to be enacted. While I would be the last to wish to add to the unemployment rolls, we must surely ask whether we can continue to subsidize with limited numbers of health-care dollars, the tremendous operating and administrative expenses of the health insurance industry. It should be clear to objective observers, as it is to technicians and experts who have studied the problem, that administrative waste in hospitals and in using physicians' time to complete forms and do other necessary paperwork is a serious and growing problem.

Just take hospital ancillary charges. Among commercial health insurers, it is common to impose an aggregate limit on ancillary charges and the benefits for such charges vary greatly. Such a system requires hospitals to separate charges between room and board, on the one hand, and ancillary charges on the other.

The paperwork accompanying this situation is estimated by our consulting actuary at 10 million charge slips a day, or 3.65 billion a year. A 1970 feasibility study by the Boston Consulting Group, funded by HEW, estimated that 63 percent of inpatient accounting operating costs could be reduced by an inclusive charge system, such as is proposed by the Health Security Act. A further saving was estimated to result from a reduction in interest costs on outstanding bills.

But this is only one part of the savings which would result from the passage of H.R. 21.

Major savings would result from the elimination of duplicative, wasteful practices of the private insurance industry. Just 1 month ago, here in Washington, at the Institute of Medicine, the Minister of Health of Canada reported that in 1969 when that country's national health program was just getting underway, the private insurance industry was collecting $1.25 in premiums for every $1 paid out in benefits. In 1973, with wholly public administration, $1.03 was collected in premiums or taxes for every $1 paid out in benefits.

SSA'S ADMINISTRATIVE PERFORMANCE

Those who believe that the best defense is a strong offense, will continue to degrade the performance of the Social Security Administration.

The disclosures about SSI overpayments have strengthened the hand of those who would play upon the public's concern about one more giant bureaucracy. Overpayments make headlines, causes of the problem are buried inside the newspapers.

The SSI program was superimposed by political appointees upon an efficient agency which is denied the manpower required to administer it, given 11th hour orders changing essential characteristics of the program, and encumbered with deficient State data.

The problem is not that the Social Security Administration is inefficient or callous to public concerns about the expenditures of public funds. Social Security is a model of efficiency whose management practices could well be replicated by private insurance companies.

The problem is not that a new program recruited too many new employees to staff it. Too few are allowed by the political bosses of HEW.

The problem is not that we have a gigantic snafu caused by the bureaucracy. The snafu was caused by the political leadership. A director selected by former President Nixon with no experience in this field offered repeated assurances that the SSI system was ready to go—the machines were in place, the manpower was adequate. After press disclosures of its inadequacies, he blamed the press, saying they were so preoccupied with Watergate that they failed to do their job of ferreting out and exposing the problems at an early stage.

Our Federal, State, and local governments employ millions of people who, Mr. Chairman, are willing to make our sytsem work, if only they are provided the opportunity through quality leadership. They are by and large dedicated and industrious men and women. The leadership which was imposed on HEW over the past few years was another matter. Here was a leadership which was determined to prove itself incompetent, surrounding itself with free-swinging critics of Government rather than able administrators, fond of crying out that Government was unable to do anything, bent on fulfilling its own prophecy.

It's easy and often politically profitably to criticize governmental bureaucracy, but the members of this subcommittee know full well that the Social Security Administration suffered no SSI-type snafus as long as its programs were run by dedicated public administrators and not politicians.

Mr. Chairman, I feel sure some of the members are concerned about press reports of the recent GAO analysis of administrative costs under medicare. As you know, the GAO analysis was undertaken at the request of Chairman Mills in 1973, at a time when the Division of Direct Reimbursement of SSA was in the process of changing its claims reimbursement procedure. Accordingly, the costs per claim paid by the Division of Direct Reimbursement were substantially higher than Blue Cross or the commercial insurance intermediaries in that year.

However, I know you will be pleased to learn, as I was, that the data for the most current year, fiscal year 1975, show that the cost per claim for the Division of Direct Reimbursement was $4.11 as compared with $5.46 for the commercial insurance companies and $4.64 for the Blue Cross plans.

In conclusion, Mr. Chairman, we urge you in the course of these hearings to hear from the people in their own surroundings and not only in Washington. We urge you also to visit Canada and to learn for yourselves what they have found to be good features and less desirable features from our neighbor to the north when its top health official reports:

> The sustained effort of the Federal Government backed by the cooperation of the provinces, has enabled us to supply Canada with a health care delivery system of prime quality that is accessible to all Canadians.

Mr. Chairman, we thank you for the opportunity to present our views and are ready to answer questions about our testimony.

[The appendix referred to follows:]

APPENDIX

COMPARATIVE COSTS OF NATIONAL HEALTH INSURANCE PROGRAMS, TOTAL NATIONAL EXPENDITURES FOR COVERED PERSONAL HEALTH SERVICES FOR FISCAL YEAR 1978 AND FISCAL YEAR 1982 (ASSUMING PROGRAMS IN FULL OPERATION)

[In billions of dollars]

	No programs	S. 3/H.R. 21	Administration	Catastrophic
Total expenditures (1978)	$142.3	$106.2	$151.1	$148.3
Through Federal budget	38.7	137.3	53.2	46.4
Social security funds	21.3	62.8	29.5	22.5
General revenues	17.4	74.5	23.7	23.9
Through State/local budget	15.5	4.5	14.1	15.4
Through insurance industry	44.8	4.2	51.5	46.4
Out-of-pocket	41.6	13.6	31.3	38.9
Other	1.7	.6	1.0	1.2
Total expenditures (1982)	222.0	210.4	235.9	231.4
Through Federal budget	60.4	180.4	83.0	72.3
Social security funds	33.3	82.6	46.0	35.0
General revenues	27.0	97.8	37.0	37.3
Through State/local budget	24.2	5.9	21.9	24.1
Through insurance industry	69.9	5.5	80.5	72.5
Out-of-pocket	64.8	17.9	48.8	60.6
Other	2.7	.7	1.7	1.9
Mechanisms:[1]				
Hospital cost controls		14.8	(7.5)	(5.1)
Physician/dentist cost controls		3.3	(3.3)	(2.1)
Other services		(6.5)	(3.1)	(2.2)
Total savings		11.6	(13.9)	(9.4)

[1] Fiscal year 1982 cost savings (cost increases) measured against "no programs" resulting from cost-containment mechanisms in each program.

NOTES

1. The primary source for these figures is table 2 from "Estimated Health Expenditures Under National Health Insurance Bills, A Report to the Congress, July 1974. See p. 4. These estimates were projected to fiscal year 1978 and fiscal year 1982 using the following inflation factors: Hospital costs, 15 percent per annum; doctors and dentists, 10 percent per annum; drugs and drug sundries, 5 percent per annum; other services, 8 percent per annum. However, it was assumed that the cost controls in S. 3/H.R. 21 would be effective to reduce costs under that bill from fiscal year 1978 (when first effective to reduce costs under these assumptions) to fiscal year 1982 as follows: hospital costs, 8 percent per annum; doctors and dentists, 5 percent per annum; other, same as above.

2. Induced costs included in the HEW study were distributed among the various categories of services in each of the programs in proportion to expenditures found in table 2 for fiscal year 1975, "total" column. Thus, the projected costs include induced costs.

3. The projected costs were then distributed by source of financing, using the percentage distribution in table 3 of the HEW study. No effort was made to adjust the projected figures to reflect the likelihood that, because hospital costs are more heavily insured than other health care expenditures, the percentage distribution would change somewhat over the years under the assumed inflation factors.

Mr. Rogers. Thank you very much, Mr. Woodcock, for a very excellent statement. We will follow the 5-minute rule. We will also follow the rule in recognizing those persons who first appeared at the committee.

Mr. Scheuer. I yield.

Mr. Rogers. Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman. I want to thank you for a very interesting statement. Would you consider renal dialysis a catastrophic illness?

Mr. GLASSER. Yes.

Mr. WOODCOCK. Obviously, since that one would be within the total business of comprehensive, yes.

Mr. CARTER. Do you realize that at the present time renal cripples are taken care of under the social security system and medicaid?

Mr. WOODCOCK. Yes.

Mr. CARTER. Then, you would do away with that form of catastrophic illness; is that correct?

Mr. WOODCOCK. No, because all such——

Mr. CARTER. According to your——

Mr. WOODCOCK [continuing]. Would be under the comprehensive umbrella.

Mr. CARTER. According to your statement, you were opposed to assistance for catastrophic illnesses, per se.

Mr. WOODCOCK. No, no.

Mr. CARTER. But——

Mr. WOODCOCK. We are opposed——

Mr. CARTER. But is that not a step forward—would you do away with that action in 1972, in December of 1972, which has saved the lives each year of 15,000 to 20,000 people?

Mr. WOODCOCK. Well, our testimony, sir, goes to the point that we start with what is in being including what you are talking about. We are saying we cannot solve this major problem by simply going down the catastrophic road.

Mr. CARTER. Would you not admit that this has been a step forward, since it saved the lives of so many people?

Mr. WOODCOCK. Obviously, in that respect, yes, sir, but in terms of solving the general health problems of the American people it is not the road that we can go down.

Mr. CARTER. You will admit it has been helpful, though, the care of renal dialysis?

Mr. WOODCOCK. Obviously.

Mr. CARTER. Thank you. I am glad you admit that.

Now, I believe that you testified on HMO's and I have supported HMO's, I supported the original health maintenance organization when it became the law, I believe in 1973. However, in your testimony this year you diminished the part of the program which would be helpful to poor people. You spoke here today that you would like to help poor people but according to your testimony, you would not permit open enrollment but you would permit skimming. That is, instead of taking a cross section of the people, you would only take those who had incomes of a certain level.

Mr. WOODCOCK. My testimony, sir, has always been that this Nation desperately needs a comprehensive universal system which takes in all Americans without exception.

Mr. CARTER. As I recall, in your testimony you did advocate the skimming policy, thus diminishing the amount of assistance to poor people.

Mr. WOODCOCK. I do not remember——

Mr. CARTER. Perhaps it was one of your people who testified.

Mr. WOODCOCK. I do not know who you are talking about.

Mr. CARTER. These statements were made. One of your emissaries made the statement and you were here at that time.

Mr. Glasser. May I comment on that? Apparently, there was some misunderstanding. We have not testified on the amendment to the HMO legislation.

Mr. Carter. This year on the HMO amendments one of their people, not Mr. Woodcock, but one of his people.

Mr. Glasser. You may be referring to the AFL–CIO.

Mr. Carter. Well, perhaps I have remembered incorrectly. However, I was concerned that the testimony supported the bill which would have restricted the good things that HMO's were supposed to have done or will actually do. The bill permits skimming and it leaves out poor people and so on. Those are the amendments that passed.

What kind of consumer participation do you envision with the health security bill?

Mr. Woodcock. Well, the whole concept of health security is that the administration, the implementation would be regionalized and all levels would have strong consumer input.

Mr. Carter. What provisions are there for preventive services in the health security bill?

Mr. Woodcock. Well, there would be almost total emphasis on the necessity for preventive services.

Mr. Carter. What would happen to the private insurance companies if H.R. 21 were enacted?

Mr. Woodcock. To private insurance companies?

Mr. Carter. Yes.

Mr. Woodcock. The Canadian experience shows that although they first tried their inclusion and found it not helpful, but they still have a role to play in the total scheme of things, and there has been no falling by the wayside of any Canadian insurance companies that I know of.

Mr. Carter. And no adverse financial impact?

Mr. Woodcock. There have been some to a degree, but certainly not of any major purpose.

Mr. Carter. What does this bill do to address the problem of cost inflation for health services over the years?

Mr. Woodcock. We continue to believe it is the only one by providing for budgetary mechanisms that goes essentially to the question of cost control.

Mr. Carter. Thank you very kindly.

Mr. Rogers. Mr. Scheuer.

Mr. Scheuer. Mr. Woodcock, let me congratulate you on an absolutely brilliant piece of testimony, which could be described as a primer in education in health services. I have three or four questions and because we are operating on the 5-minute rule, I am going to ask them all at this time. Then, if you do not get through all of the answers, perhaps you could give me the answers to the ones that you do not have the time to answer, in writing.

No. 1. I take it you feel the payroll tax mechanism is the best way to finance a health insurance system. If that is not true, how do you the payroll tax mechanism as opposed to appropriations from the the payrool tax mechanism as opposed to appropriatons from the General Treasury is desirable?

Second question, Your H.R. 21, I guess, is the most extensive and comprehensive health program that we are facing at the present time. If, because of the exigencies of financial constraint, we decide we are unable at this time to put the whole edifice into effect, are there any elements, are there any pieces of brick or mortar which you think we could put in place a pending completion of the edifice over perhaps a period of several years?

In other words, are there elements that you think that we can start in with now and, if so, what are they?

Third. I note from your program you have no deductibles, that it is entirely a free system.

I have been to England, and I have talked to leading figures in English health affairs, and to the heads of the British Medical Association. Incidentally, I am also sure that this committee will take your advice and go to Canada if there is something to be learned there. The one thing the British tell us is not to have a system where everything is free. That is the biggest mistake that we have made, say the British, because we have absolutely no way of controlling frivilous overuse of the system.

How do you propose to control overstress and overuse of the system without any financial contribution or participation on the part of the consumer?

No. 4. Your legislation would significantly extend the bureaucratic task of the Federal Government. There is not a Member of Congress who does not get persistent and systematic complaints about the bureaucracy under medicaid.

With such a great expansion of jurisdiction, how do you propose that the administrative mechanism be made responsive to individual needs of cities, States, counties, municipalities, and even neighborhoods?

Mr. Florio. Would you yield? The question the gentleman has asked and other questions asked are obviously very significant and important. Clearly, time does not permit responses in any meaningful form. Would it be appropriate if any of the witnesses desire to respond in writing, after they give their verbal response, the rest of the committee get the answers to these questions?

Mr. Scheuer. Of course.

Mr. Rogers. Certainly, that would be done.

Mr. Woodcock. First, with regard to the financing. H.R. 21 provides for payroll taxes up to the limit of $21,000 on the worker, on the gross payrolls of the employer, which it is estimated would bring in 50 percent of the needed revenues. The balance would come from the general revenues.

With regard to the impact on the Federal budget——

Mr. Scheuer. May I ask you, what is the purpose of having a payroll tax if the system is going to support people who are not employed, who are retired, elderly people, unemployables? Why not go to the General Treasury to support the system, since the General Treasury is involved in any event?

What is the function of the payroll tax?

Mr. Woodcock. When the Congress put the medicare system in place it was through the mechanism of this payroll tax.

Mr. Scheuer. What we want to do is depart from past errors. What is the significance of the payroll tax? Why do you not look to the General Treasury?

Mr. Woodcock. Because of the feeling of individual input from those who are employed and the whole theory of the social security system is that there is the individual input so it tends to be in the form of an earned right not a gratuity that came, as it were, from heaven.

Mr. Scheuer. Throughout your testimony you talked about health care being a right of American citizens that should be emphasized on our Bicentennial. Now you are saying that it is not a right, that if you are not employed you have not earned it.

Mr. Woodcock. There can be a right but someone has to pay for that right. This contemplates that the American people as a whole, those who are in position to pay for it would pay for it.

Mr. Scheuer. They are going to pay for it out of the General Treasury. We have a somewhat progressive tax structure in this country.

Mr. Woodcock. To some degree.

Mr. Rogers. I am sorry to have to interrupt.

Mr. Scheuer. I would be delighted if you filed answers to the other questions in writing.

[The following questions and answers were received for the record:]

Questions Asked in Writing by Mr. Scheuer and Mr. Woodcock's Answers

Question 1. Why do you think a payroll tax mechanism is the best way to finance a national health insurance system?

Answer. The payroll tax mechanism has been used successfully for 40 years as a social security financing mechanism. When the Health Security Act passes, it is proposed that 50% of funds come from general revenue and 50% from payroll taxes. This is a realistic and practical proposal for financing health services. The employer will contribute 3.5% of total payroll and the employee 1% on a wage base that is 150% of the social security wage base. While benefits would not be conditional on work earnings tests or any other test except the need for the health care services, the concept of "earned right" attached to social insurance as against the welfare stigma associated with social services financed totally through the general tax system, would be preserved and extended into health care.

Mot unions have negotiated contracts which cover health benefits. Nonunion employer groups also are providing some form of health insurance to their employees. Employers are, therefore, presently paying substantial premiums for coverage. Under Health Security, most employers would not be burdened additionally by the payroll tax since they would be relieved of premium payments. Their financial contributions would be transferred from premium payments to tax payments.

A payroll tax is clearly superior to paying insurance premiums which are determined by the insurance companies on the basis of degree of risk, the amount of profit, and without any social benefit. Premiums are the most regressive method of financing health benefits.

The question of financing national health insurance totally from general revenue is presently not feasible and such a proposal could delay enactment of national health insurance for year. Under the banner of progressive taxation, the nation would be left with a defective health care system, regressively financed.

Question 2. H.R. 21 is by far the most extensive health reform bill now before Congress. In view of the stalemate in the discussion about health insurance legislation, are there elements of your program about which you are prepared to entertain a compromise position?

Answer. We have always maintained that the provisions of the proposed Health Security bill are not cast in cement and can be changed, provided that basic principles are not violated. These include the goals of universal coverage and its corollary of health care as a right, the provision of comprehensive benefits, and the maintenance of cost and quality controls. We are unalterably opposed to the incremental approach of catastrophic insurance, because it would serve to further inflate costs and exercise no controls on the system in a way that Medicare inadvertently has inflated costs without adequate controls.

We are further commited to the enactment of Health Security as a total package, although certain parts of it can become functional at specified future dates. For example, in the proposed legislation two years are designated as a tooling-up period. Furthermore, dental benefits are provided for children under 15, with provision for dental coverage to be extended to other age groups sequentially in a specific time period. We think this evolutionary approach would provide the best method of attaining the goals of delivery of health care that are commensurate with our nation's scientific achievements in the field of medicine.

Question 3. Without deductibles, how much increased utilization do you anticipate with the passage of this type of legislation?

Answer. We do not see deductibles as a mechanism for holding down utlization, yet we do see the probability of a slight but easily handled increase in utilization with or without deductibles.

Deductibles, at best a weak control on costs, are more generally a nonexistant control or even an inflator of costs. Deductibles do stand as a barrier to the poor or near poor in regard to preventive medicine, or early treatment of diseases, often however, necessitating more expensive care at a later date. Yet for rich or poor it is a non-existant barrier to hospital services for it is the emergency condition or the doctor which decides hospital admission.

The irony of using deductibles as a control mechanism on the patient is seen in the Medicare program. Here in 1973, 57% of the Medicare recipients had purchased additional, or coinsurance, to pay for their deductibles. With the deductibles paid automatically by the coinsurance they have no barrier effect at all. The major effect of the deductibles is that the insurance companies, which promote them as a necessary cost control mechanism, are now making a lot of money by selling coinsurance to pay them (see attached letter on Medicare Supplementary Insurance Plan).

A study by Milton Roemer et al in California (study attached) using co-pay-illustrated a similar point. Those in the groups obligated to additional co-pay initially had lower utilization rates than those in the control group with no co-pay. However, in the long run, there was a higher utilization rate of hospital and high cost services and the money collected by the additional revenue from co-pay was more than offset by the costs of the additional needed hospital services. Co-pay was abolished.

We therefore consider the question of increasing utilization a subject unrelated to deductibles. We do anticipate increased utilization, based on the experience in Canada. This would be minimal and be concentrated particularly at the preventive level, for people in the medically near-poor category. These people who had little or no access to preventive care will, hopefully, make better use of the medical system to keep them well. However, it has been the experience again of our Canadian neighbors that, after they adopted national health insurance, there was an initial surge in the number of patients. (This was generally due to people holding off on seeking medical help in the months before the inception of the program). However, after the first year, there was a levelling off with the utilization rate increased only slightly. (This is documented in a June 4, 1973 address of Dr. R. A. Armstrong, Canadian, Director General, Health Insurance).[1] It was found that all of this could be handled by readjustments in manpower, with some of the specialists spending more time at family medicine.

I do not feel that the increased demand on our system would be substantially different from that of Canada. I think that with the two year tooling-up period written into the Health Security Act, with its emphasis on new manpower development, and with the infrastructure of planning and resources development, legislation already laid in place, there will be no unmanageable demands upon the system resulting from this type of legislation.

Question 4. My office often gets complaints about how long it takes providers to be reimbursed through Medicaid, citing bureaucratic red tape and inefficiency. This legislation extends the administrative tasks of the federal government. What is the evidence that such a system will be flexible and responsive to the individual needs of states, cities and localities?

Answer. We regard the experience of Medicaid as a disaster—with conditions of entitlement and benefit provisions varying tremendously from state to state. Health Security, on the contrary, would eliminate means tests and variable and confusing benefit provisions which cause bureaucratic red tape and frustrations.

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[1] This statement, with attachments, may be found in committee files.

Federal standards would be established and benefits would be comprehensive and equal for all, rich or poor, old or young. It would be a well ordered system with prospective regional budgets and priorities established locally and regionally, in consultation with state and local authority.

Question 5. What are the problems with the private health insurance industry and what is its current role?

Answer. The problems are legion. Competition among the 1,500-plus health insurance carriers and organizations serves to drive up hospital and medical costs, not to restraint them. In order to limit premium costs, benefits are often limited to hospital and hospital-associated services. Cost and quality controls are not exercised. Preventive medicine is discouraged by deductibles, coinsurance and exclusions. Pre-existing condition clauses deny coverage and benefits to many. The existing defective delivery system is supported and innovative approaches discouraged. In short, things work well for preserving the status quo and therefore serve the interests of insurors and providers, but not consumers.

The problems with the present private health insurance system are based on the misconception that medical field works on pure free enterprise principles, and that the health insurance system does the same. Neither is true. Doctors and hospitals are not in price competition and have no incentives to keep prices or costs down.

As to the current role, data published in September 1975 by the Department of Health, Education, and Welfare, show great gaps in coverage (Table 1), the limitations in coverage related to low and middle-income (Table 2), the low proportion of personal health care expenditures met by private health insurance—only 25.2 percent in 1973 (Table 3), and financial experience of the private companies, with 47 percent of premium income for individual policies and 13 percent for group policies retained by the insurance companies, and seven percent retained by Blue Cross and Blue Shield combined (Table 4).

REFERENCES

1. Table I—The Gaps in Private Health Insurance Coverage
2. Table II—Health Insurance Coverage Related to Income
3. Table III—Proportion of Personal Health Care Expenditures Met By Private Insurance
4. Table IV—Financial Experience of Private Health Insurance Organizations

TABLE I

THE GAPS IN PRIVATE HEALTH INSURANCE COVERAGE

The post-World War II development of fringe benefits through collective bargaining and the growth of union-management health and welfare funds have stimulated the tremendous growth of voluntary health insurance in the United States. According to ORS estimates, nearly four-fifths of the population under age 65 had some form of private health insurance at yearend 1973, but the amount and types of coverage often are limited Seventy-eight percent had hospital coverage and some protection against surgical costs; 77 percent were covered at least in part for in-hospita physician visits and X-ray and laboratory examinations. The percentage were lower for other nonhospital-associated health care--35 percent wer covered for office and home visits; 65 percent for out-of-hospital prescription drugs (subject both to deductibles and other limitations); 33 percent for nursing-home care; and 11 percent for dental care.

About 22 percent of the civilian population under age 65 (representing some 41 million persons) was wholly unprotected by private health insurance in 1973. Disproportionate numbers of these were children and the poor, whose medical care may have been covered under Medicaid. Medicai payments were made in behalf of about 20.9 million persons in fiscal 1973--45.2 percent were children and 16.8 percent were persons aged 65 and over. The percentage of persons aged 65 and over with private heal insurance coverage was generally much lower, largely because of their coverage under the Medicare program.

Type of care	Population under age 65			
	With coverage		Without coverage	
	Number (in millions)	Percent	Number (in millions)	Percent
Hospital care..............	146.1	78.0	41.3	22.0
Surgical services..........	145.4	77.6	41.9	22.4
In-hospital visits.........	144.6	77.2	42.8	22.8
X-ray and lab exams........	144.0	76.9	43.4	23.1
Office and home visits.....	65.9	35.2	121.5	64.8
Dental care................	21.4	11.4	166.0	88.6
Prescription drugs.........	121.0	64.6	66.4	35.4
Nursing-home care..........	62.6	33.4	124.7	66.6
Private duty nursing.......	115.2	61.5	72.2	38.5
Visiting nurse service.....	117.9	62.9	69.5	37.1

Source: Marjorie Smith Mueller, "Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, Feb. 1975.

TABLE II

HEALTH INSURANCE COVERAGE RELATED TO INCOME

The lower a person's income, the less likely he is to have health insurance. In 1970, only 39 percent of persons in families with incomes under $3,000 had hospital insurance coverage. In contrast, an overwhelming proportion--90 percent--had hospital coverage in the $10,000-plus group. In general, the proportion of the population with hospital insurance coverage increases as income increases.

Similarly, income is probably the most important factor in determining whether a family has surgical insurance. Only about a third of the poor, compared with almost nine-tenths of those in the highest income bracket, had this type of coverage.

Income level	Percent of population under age 65 with--	
	Hospital insurance	Surgical insurance
Under $3,000...............	39.3	36.7
$3,000-$4,999..............	53.1	50.2
$5,000-$6,999..............	74.5	71.8
$7,000-$9,999..............	84.3	81.9
$10,000 or more...........	90.1	88.3

Source: "Hospital and Surgical Coverage Among Persons Under 65 Years of Age in the United States, 1960." *Monthly Vital Statistics Report,* U.S. Department of Health, Education, and Welfare, National Center for Health Statistics.

TABLE III

PROPORTION OF PERSONAL HEALTH CARE EXPENDITURES MET BY PRIVATE INSURANCE

From 1950 to 1973, private health insurance paid for an increasing proportion of total expenditures for personal health care. In that period health expenditures grew annually at an average rate of 9.4 percent while insurance benefits increased 14.3 percent. As a result, the share met by insurance grew from less than one-tenth in 1950 to over a fourth in 1973.

Year	Personal health care expenditures 1/ (in millions)	Private insurance benefits	
		Amount (in millions)	Percent of expenditures
1950	$10,885	$992	9.1
1955	15,708	2,536	16.1
1960	23,680	4,996	21.1
1965	34,821	8,729	25.1
1970	63,652	15,744	24.7
1971	70,559	17,713	25.1
1972	78,052	19,526	25.0
1973	85,894	21,614	25.2
	Average annual percentage increase		
Period:			
1950-55	7.6	20.6	---
1950-73	9.4	14.3	---
1955-60	8.6	14.5	---
1960-65	8.0	11.8	---
1965-73	11.9	12.0	---

1/ All expenditures for health services and supplies other than (1) expenses for prepayment and administration, (2) government public health activities, and (3) expenditures of private voluntary agencies for other health services.

Source: Marjorie Smith Mueller, "Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience," *Social Security Bulletin,* Feb. 1975; Nancy L. Worthington, "National Health Expenditures, Calendar Years 1929-73," *Research and Statistic Note No. 1, 1975,* Social Security Administration, Office of Research and Statistics.

TABLE IV

FINANCIAL EXPERIENCE OF PRIVATE HEALTH INSURANCE ORGANIZATIONS

In 1973 the subscription or premium income of all private health insurance organizations totaled $24.5 billion. Benefit expenses amounted to $21.6 billion, or 88.1 percent of premium income. The organizations used $3.4 billion for operating expenses (13.7 percent of premium income) and had a net underwriting loss of $438 million (1.8 percent), some of which was made up by income from investment of reserves.

Operating expenses differ among private health insurance organizations. Commercial insurance companies have costs for claims adjustment, commissions, other acquisition, field supervision, general administration, taxes, licenses and fees. Blue Cross-Blue Shield and other nonprofit private health insurance plans are generally exempt from premium and income taxes, but they do have acquisition costs. The operating-expense ratio of insurance companies was almost three times that of Blue Cross-Blue Shield, largely due to their very high operating expenses for individual business (47 percent of premium income).

Group business of insurance companies and independent health insurance plans had the highest claims ratios--they returned 92.9 percent (group insurance business) and 94.9 percent (independent plans) of premium or subscription income in benefits. The individual business of insurance companies paid out only 58.6 percent of premium income in benefits. Blue Cross-Blue Shield plans returned 90.5 cents of every subscription dollar in benefits.

Type of plan	Subscription or premium income	Claims expense	Operating expense	Net underwriting gain or loss
	Amount (in millions)			
Total..............	$24,532.3	$21,614.1	$3,355.7	-$437.5
Blue Cross-Blue Shield.....	11,059.1	10,004.2	775.3	279.6
Blue Cross...............	7,862.1	7,187.3	407.7	267.1
Blue Shield..............	3,197.0	2,816.9	367.6	12.5
Insurance companies........	11,694.0	9,930.0	2,446.4	-682.4
Group policies...........	8,970.0	8,333.0	1,166.1	-529.1
Individual policies......	2,724.0	1,597.0	1,280.3	-153.3
Independent plans..........	1,779.2	1,679.9	134.0	-34.7
Community................	706.2	684.0	47.0	-25.0
Employer-employee-union..	817.4	778.0	58.4	-19.0
Private group clinic.....	25.8	17.7	3.8	4.3
Dental service corporation	230.0	200.2	24.8	5.0
	Percent of premium income			
Total..............	100.0	88.1	13.7	-1.8
Blue Cross-Blue Shield.....	100.0	90.5	7.0	2.5
Blue Cross...............	100.0	91.4	5.2	3.4
Blue Shield..............	100.0	88.1	11.5	.4
Insurance companies........	100.0	84.9	20.9	-5.8
Group policies...........	100.0	92.9	13.0	-5.9
Individual policies......	100.0	58.6	47.0	-5.6
Independent plans..........	100.0	94.4	7.6	-2.0
Community................	100.0	96.9	6.7	-3.6
Employer-employee-union..	100.0	95.2	7.1	-2.3
Private group clinic.....	100.0	68.6	14.7	16.7
Dental service corporation	100.0	87.0	10.8	2.2

Source: Marjorie Smith Mueller, "Private Health Insurance in 1973: A Review of Coverage, Enrollment and Financial Experience," *Social Security Bulletin,* Feb. 1975.

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IMPORTANT ANNOUNCEMENT FOR SENIOR CITIZENS

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On July 1, 1966, the Federal Government formed an insurance program for senior citizens, called MEDICARE.

Since the endorsement of the program, there have been many inquiries concerning the benefits available under MEDICARE. Most elderly people are deeply concerned about the benefits available to them, and are not quite sure exactly what is covered and what is not covered.

MEDICARE was formed to HELP people with the rising costs of medical care. However, since 1966, Medicare Deductibles have been increased periodically, and this year these deductibles have been increased once again; therefore, you must pay an even greater portion of the hospital bill. MEDICARE does NOT pay the entire cost; YOU must pay part of the bill. Because of this, it is important that you fully understand the benefits that are available to you.

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Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish

MILTON I. ROEMER, M.D., CARL E. HOPKINS, PH.D., LOCKWOOD CARR, B.S., AND FOLINE GARTSIDE, M.A.

The California "copayment experiment" imposed a charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month, effective January 1, 1972. Data on utilization rates were gathered for six months before this date and for 12 months after it. While other administrative requirements, like prior authorization of certain services, doubtless also played a part, it was found that, following the start of copayment, utilization of ambulatory doctor's office visits and other services associated with them showed a decline, relative to that of the non-copayment cohort. After a brief lag, however, hospitalization rates in the copay cohort rose to levels higher than those of the non-copayment cohort—more than offsetting the savings to the state from the reduction of ambulatory service use rates. Due presumably to the neglect of early medical care because of the inhibiting effect of the copayments, these higher use rates of costly hospitalizations suggest that financial deterrents on access to ambulatory service by poor people are penny-wise and pound-foolish, not to mention their effects on health and well-being.

Note: The following paper was prepared and submitted before the publication of "California's Medi-Cal Copayment Experiment" by Earl W. Brian and Stephen F. Gibbens as a special Supplement to the December 1974 issue of this journal. Although examining the same medical care program, our study is based on a cohort analysis over time—before and after the imposition of copayment requirements—and applies statistical techniques which adjust for the critical differences in "test" and "control" populations, not done in the previous report. Moreover, it examines hospitalization experience not only because of its costliness but especially because of its value as a reflection of the long-term effects of the demonstrated reduction in ambulatory services. As a result, our conclusions on the ultimate consequences of copayment fees for ambulatory services in a low-income population are very different from those of Brian and Gibbens.

ONE OF THE persistent subjects of debate in planning health insurance or other financial support programs for medical care is the effect of copayment or deductible requirements. Applied in many programs, both private and governmental, the general assumption has been that these cost-sharing charges would inhibit "unnecessary" or "frivolous" demands for medical care, and therefore reduce the burden on the fiscal source and available health manpower.[2]

Copayment as a Deterrent to Use of Medical Care

Much research has been done on the question of copayment as deterrent, with conflicting findings. Obviously the effects of cost-sharing on utilization or demand depend on the amount of money involved—either in fixed dollars or percentage of charges, on the income level of the insured, on whether the copayment applies to a service ordered by the doctor (like hospitalization) or to one initiated by the patient (like an ambulatory visit), and on other factors. The weight of evidence seems to

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Support for the research reported in this paper was given by the U.S. Social and Rehabilitation Service (SRS Project Grant 18-P-56696/9).

suggest that for services decided upon by the doctor, if the cost-sharing requirement is small, the effects are transitory or virtually nil.[5] For patient-initiated services, on the other hand, the inhibiting effect of copayments on utilization may be substantial, but especially so for lower income families.[1]

A depressing effect of copayments on consumer demand obviously reduces medical care expenditures in the short run, even if one counts both personal outlays and payments from a social (insurance or revenue-derived) fund. For the social fund, moreover, the saving results from two mechanisms: 1) the reduction in numbers of medical claims, and 2) the nonpayment by the fund of the copayment amount itself. These fiscal effects, however, tell us nothing about the medical or health consequences of the copayments. It certainly cannot be inferred that a patient's failure to see or delay in seeing a doctor for a symptom means that the ambulatory visit was unnecessary or frivolous. It means only that the copayment obligation effectively inhibited the procurement of care, whether it was medically advisable or not. A recent review paper by researchers from the Rand Corporation, for example, draws the conclusion that copayments reduce ambulatory care demand, thereby saving health insurance funds; it does not consider, however, the possible effects on health.[6] Nor does it consider the later demands for care that these health effects might generate, perhaps more than offsetting any initial savings.

An investigation of the so-called "California Copayment Experiment" (hereafter called COPE) which operated under the Medicaid program from January 1972 until July 1973 provided us with an opportunity to probe this question—that is, the longer term effects on health and costs of a small copayment obligation imposed on Medicaid beneficiaries as a condition for visiting a doctor and for having a prescription filled. Examining the experience of the California COPE program before its start and for 12 months after permitted some inferences on both these matters.

The California "Experiment" and Its Assessment

In brief, the California State Department of Health Care Services imposed a copayment charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor each month after January 1, 1972. The doctor or his assistant was expected to collect the dollar and, whether he did or not, the State deducted one dollar from the fee payable under the program. Similarly, a 50 cent copayment was imposed for the first two drug prescriptions each month, this amount to be collected by the pharmacist. A survey of providers showed that over 80 per cent of the doctors and 90 per cent of the pharmacists did, in fact, collect the COPE charges.

Under the original Medicaid law (which barred states from imposing any payment obligations on the indigent beneficiary for statutorily required medical services), this California measure could be approved by the federal Department of Health, Education, and Welfare, only if it was considered an "experiment." Our research group at UCLA, which was called upon by the federal Department to evaluate the results, was not involved in the experimental design. Had we been, we would have much preferred to establish two randomly chosen or matched populations of Medicaid beneficiaries, one of which was required to copay while the other was not. Instead, the State—perhaps in the interests of compassion—decided to impose the copayment obligation only on those Medicaid beneficiaries who had some additional financial resources outside their statutory cash benefits, while not imposing it on the rest of the eligible persons.

Thus the two populations, with respect to "copay" or "no-pay" status, were not basically alike. The copay group, constituting families with some resources, tended to be a decidely older-age population. Even though our evaluative study was confined to AFDC (Aid to Families with Dependent Children) beneficiaries, the children in the copay families tended to be older. Moreover, the very existence of some extra resources in these families meant that their standard of living and perhaps other cultural characteristics were likely to differ from those in the more impoverished no-pay AFDC population. These differing sociodemographic characteristics would inevitably influence tendencies to seek medical care and meant, unfortunately, that our evaluative research could not be based on a simple comparison of the trend lines of the medical care demand rates of the two populations.

Instead, it was necessary to establish two cohorts of copay and no-pay populations, to follow their demand rates for a reasonable length of time both *before* and *after* the imposition of the copayment charge, and then to compare not the absolute rates but the *relative* levels of utilization of various types of medical care by the two populations. This could be achieved by establishing a base period, prior to copayment, at which the actual utilization rates of the two populations were converted to a common *index* figure of 100. Then one could follow the trend lines for the indices of the two cohorts to determine whether, after the imposition of copayment in one cohort, a difference was observable in the demand or utilization trends followed by each.

Since California is a large state, and our research funds were limited, we could not examine the total experience of the State's over 2,000,000 Medicaid beneficiaries. We chose instead the AFDC universe within three counties (San Francisco, Tulare, and Ventura) believed to be fairly representative of the State as a whole, both in urban-rural distribution and in ethnic or racial composition of Medicaid persons.* In these three counties, the copay cohort population throughout the observations numbered 10,687 and the no-pay cohort numbered 29,975, or a ratio of roughly 1:3. This ratio was also characteristic of the Medicaid population in the State as a whole.

To establish the basis for these two trend lines, as noted above, a time span was studied beginning six months before the copayment charge was imposed and ending 12 months after. Computerized data were examined for medical and related claims paid for services actually rendered during six quarterly (three-month) periods over this 18-month span. The exact quarters for which service data (from paid claims data tapes) were collected are shown in Table 1.

TABLE 1. Service Data Collection Quarters

Quarter	Time-Period	Status
1	July-September 1971	Before copayment
2	October-December 1971	Before copayment
3	January-March 1972	Copayment started (Jan. 1)
4	April-June 1972	Copayment in effect
5	July-September 1972	Copayment in effect
6	October-December 1972	Copayment in effect

Findings

In Table 2 are presented the actual rates of doctor's office visits per 100 eligible AFDC Medicaid beneficiaries over the 18-month study period. Also presented in this table are the same rates, adjusted to an index figure of 100 for the first quarter, as

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* Originally, information had been obtained on seven counties, but examination showed so many serious gaps and problems in the claims and eligibility data in four of the counties that we felt compelled to reduce the sample to three counties; in these, the data were satisfactory for analysis.

TABLE 2. Doctor's Office Visit Rates for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number per 100 Eligibles per Quarter-Year, and Indices of Rates Based on Quarter 1 = 100

Quarter	Doctor's Office Visits per 100 Eligibles		Index of Office Visit Rates (Quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
1	79.54	75.47	100	100
2	66.79	59.98	84	79
Copayment Started				
3	79.09	69.13	99	92
4	71.24	64.77	90	86
5	67.46	59.55	85	79
6	73.18	66.31	92	88

Note: Illustrated graphically in Figure 1.

explained above. Graphic presentation of the index figures from Table 2 appear in Figure 1.

Interpretation of this table (and subsequent tables and figures) requires further explanation about the course of events in California's Medicaid program over this 18-month period. In October 1971, at the start of Quarter 2, a number of administrative changes were introduced in the program; most important among these was a requirement of prior authorization from a State

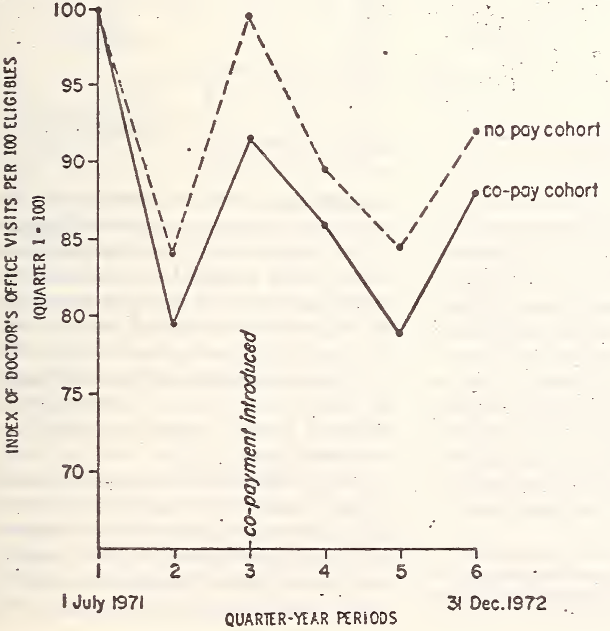

FIG. 1. Doctor's office visit rates for AFDC families, by copayment status in California Medicaid program, July 1971-December 1972; indices of rates based on Quarter 1 = 100.

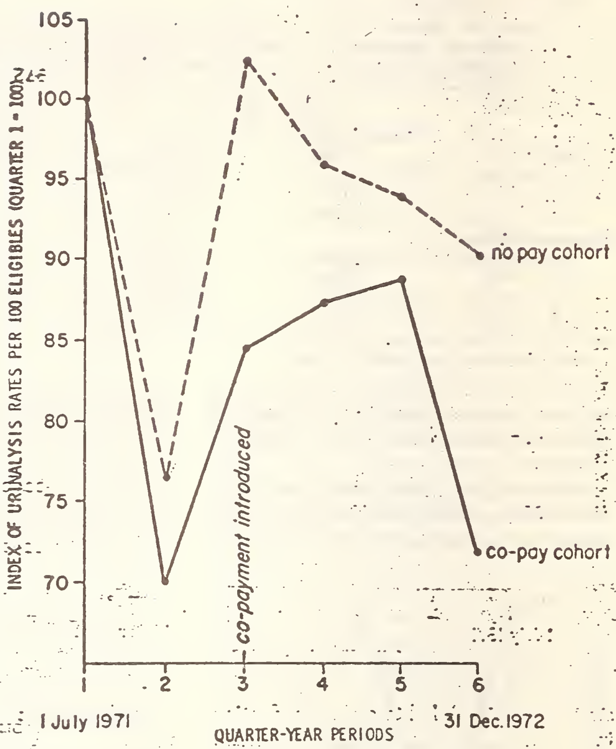

FIG. 2. Urinalysis rates for AFDC families, by copayment status in California Medicaid program, July 1971 – December 1972: indices of rates based on Quarter 1 = 100.

Medicaid Consultant for more than two ambulatory services or more than two prescriptions in any month. It is evident that this requirement was associated with a sharp decline in utilization rates of *both* the no-pay and copay cohorts for Quarter 2, even before copayment was introduced.[3] Prior authorization for ambulatory services beyond two per month, for nonemergency hospital admissions,† and for certain other services was a continuous requirement for both cohorts throughout the remainder of these observations. It is not possible to disentangle the inhibitory effect of this requirement from the copayment obligation in the copay cohort, but its substantial effect may be estimated from the trend line for the no-pay cohort. Probably seasonality also had some effect on both trend curves—for example, the rise in doctor's office visits and drug prescriptions in the sixth quarter for both groups was very likely associated with fall-winter (October-December) respiratory disease.

Keeping in mind the combined effect of the prior authorization requirement, as well as the different sociodemographic composition of the two cohorts, it would appear from these data that the prior authorization requirement, after its introduction at the

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† This restriction had, in fact, been operative since April 1968. Such prior authorizations, of course, have been used to restrict medical care use in welfare program for centuries.

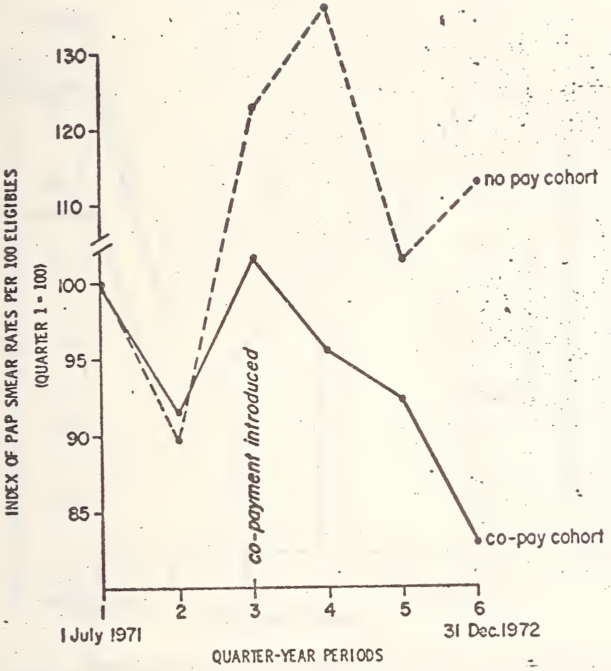

FIG. 3. Pap smear rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

start of Quarter 2, led to a sharp reduction in the rate of ambulatory doctor visits. Then for subsequent quarters, while seasonality and disease incidence associated with it may have been exerting an influence, the copay cohort had a rate of doctor's office visits—relative to the base period for the index—substantially below that of the no-pay cohort throughout the study span. There would seem to be little doubt that this differential was due to the copayment requirement.

Continuing, for the sake of simplicity, with the data simply in graphic form, we can consider a common diagnostic laboratory test, urinalysis, in Figure 2, and a common preventive screening test, the Pap smear, in Figure 3. By both of these trend lines, it is apparent that the copay cohort had substantially lower utilization indices than the no-pay cohort. In Figure 4, the use of prescription drugs, with a 50-cent copay requirement, shows similar relationships. All three of these types of service were associated with ambulatory doctor's visits, for which copayments were usually required.

Table 3, however, presents data for the two cohorts, with an important distinction. It applies to the hospital patients, and—while showing rates and indices separately for both cohorts—no actual copayment was required from either population, and the decision on hospitalization was made by the doctor.[**] The same data are shown in graphic form in Figure 5. The data in Table

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[**] Our data are based on an unduplicated count of hospital *patients*, rather than admissions, which may have amounted to more than one for some patients.

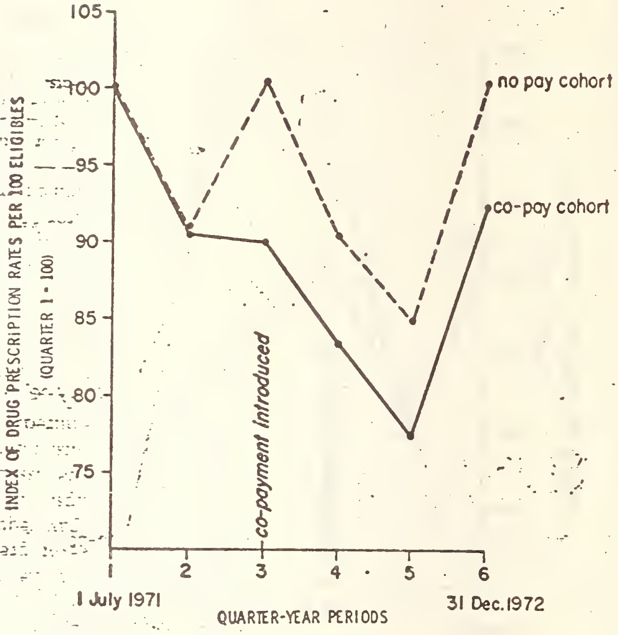

FIG. 4. Drug prescription rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

3 and Figure 5, in sharp contrast to trends in all previous tables, show that after introduction of copayment in January 1972 the index figures for the copay cohort leaped up to a *higher* level than those for the no-pay cohort. They remained at a higher level for three of the four copayment quarters. The drop in the final quarter may

TABLE 3. Hospital Patient Rates* for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number Hospitalized per 100 Eligibles per Quarter-Year, and Indices of Rates Based on Quarter 1 = 100

	Hospital Patients per 100 Eligibles		Index of Hospitalization Rates (Quarter 1 = 100)	
Quarter	No-pay	Copay	No-pay	Copay
1	3.56	2.54	100	100
2	3.07	2.09	86	82
Copayment Started				
3	3.12	2.37	88	93
4	2.88	2.14	81	84
5	3.05	2.29	86	90
6	2.70	1.71	76	67

* Data are based on an unduplicated count of hospital *patients* during a quarter year, rather than admissions, which may have been more than one for some patients.

Note: Illustrated graphically in Figure 5.

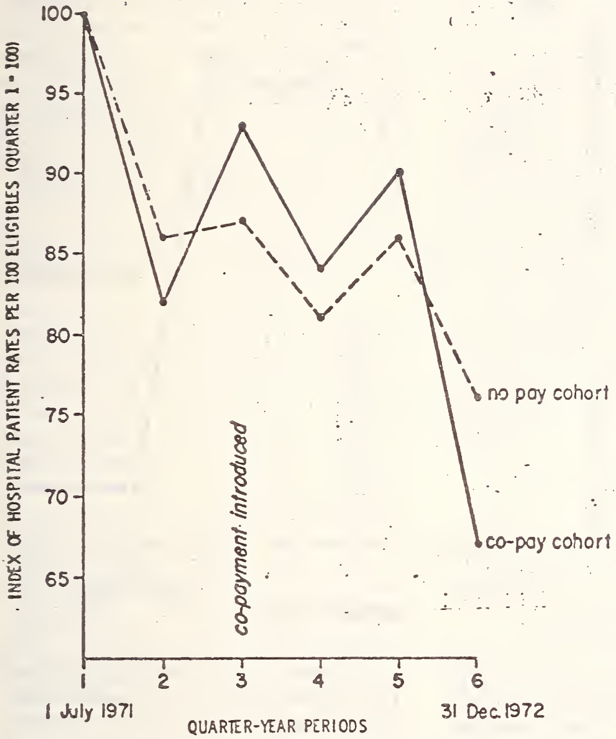

FIG. 5. Hospital patient rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

simply reflect the completion of hospitalizations in the previous three quarters for persons needing such care, as well as the usual overall drop in hospital use around the Christmas holiday season.

Figure 6 presents the hospitalization rates on another basis. It shows the trend of indices for all diagnoses except those related to pregnancy. The latter may be regarded as "nature-generated" and relatively independent of a doctor's judgment in modern American society. With these cases removed, it is apparent that the differentially higher indices of hospital use for the copay cohort are even greater in three out of the four copayment quarters than for the total of hospital patients shown in Figure 5.

Discussion

These findings suggest that the effects of copayment requirements for ambulatory services (and prescriptions) in a medical care program for low-income families were to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to drug prescriptions. Easy access to and use of general ambulatory doctors' services are widely considered to have preventive value, by permitting prompt diagnosis and treatment of an illness before it becomes more serious.

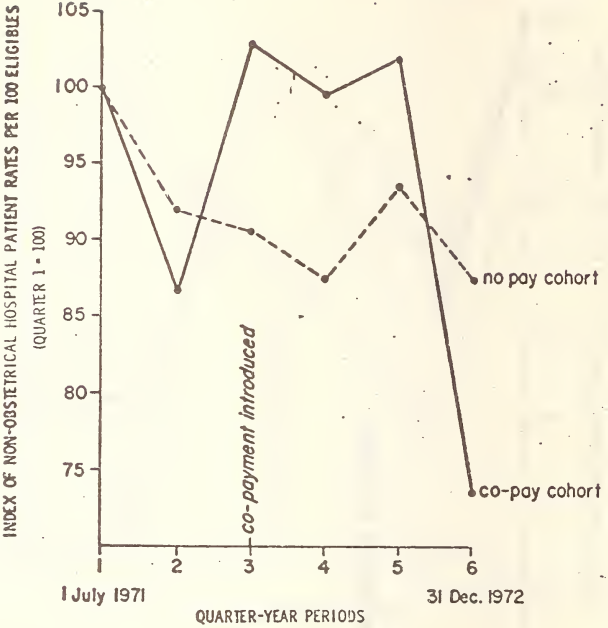

FIG. 6. Hospital patient rates for all non-obstetrical admissions in AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

When such ambulatory services are inhibited, it would seem that a price is paid—namely, a rise in the relative rate of hospitalization. It is likely that this elevated hospitalization rate is due to the postponement of ambulatory care, so that when the patient is finally driven to seek assistance, his case is more advanced and requires inpatient care. This interpretation is supported by the general observation in the U.S. National Health Survey of longer hospital stays among low-income persons, even for the same diagnosis, in the nation as a whole.[8] This is likewise associated with lesser rates of ambulatory doctor's care by the poor generally and is usually interpreted along the lines offered above.

A clear-cut reduction in diagnostic tests (urinalyses, Pap smears, and others) as well as ambulatory treatment (doctor visits and prescriptions)—as found in our study—could hardly be expected to benefit health status. This is quite aside from the pain and suffering involved for the low-income patient, who postpones seeking medical care at early stages of his illness.

These findings also have serious financial implications. Hospitalization is by far the costliest sector of medical care. A reduced rate of ambulatory care may yield short-term financial savings, but a subsequent increase in the rate of hospital use could more than outweigh these amounts.

To determine the net financial effect within the copayment cohort, we may estimate an expected cost to the State, based on the rate of office visits in the quarter preceding the initiation of copayment, which was on an annual basis 2,400 visits per 1,000 (much lower, incidentally, than the rate in the general population, and hardly justifying the State government's assertion of "overutilization"). Multiplying this by the cost-per-visit of $8.79 in that quarter yields an "expected" cost of $21,096 per 1,000 eligibles. After copayment was initiated, the actual cost for the year was $21,008 or a theoretical net saving to the state of just $88 per 1,000.[‡]

Turning to the hospitalization experience, the "expected" expenditure would be based on the base-period rate of 83.6 patients per 1,000 per year at a cost of $623 per patient (the annual cost per patient in the copayment period) or a total of $52,082 per 1,000. Actually, the expenditure in the copayment period was $53,017 or a net excess of $935 per 1,000. (It should be noted that this excess was due entirely to the increased hospitalization rate; if one took account of actual inflation of hospital costs over the precopayment period, the difference would be much greater.) Substracting the estimated saving for ambulatory services of $88 per 1,000, the net excess cost to the state was $847 per 1,000 eligibles. Thus, for the approximately 1,450,000 AFDC beneficiaries in California, the overall *excess cost* to the State was $1,228,150. (It is noteworthy that California discontinued the entire copayment procedure June 30, 1973, even though federal P.L. 92-603, effective January 1, 1973, officially permitted such copayment under certain circumstances.)

In a word, it would appear from this study of the California Copayment Experiment with Medicaid beneficiaries that the State government's strategy was penny-wise and pound-foolish. Short-term savings for lower ambulatory care use were followed by definite increases in costly hospital use. It is of interest to note that this general course of events was predicted in a legal brief submitted in opposition to the copay program before it was instituted.[4] As the experience of many "health maintenance organizations" has repeatedly demonstrated, comprehensive medical care, without cost-sharing deterrents, is probably not only the best way to maintain a person's health, but is also most economical in the long run.[7]

[‡] In spite of the lower indices of office visit rates for the copay cohort, compared with the no-pay cohort (shown in Table 2 and Figure 1), it may be noted that the actual rate of visits of both cohorts (for epidemiological or other possible reasons) exceeded the precopayment rate during three out of the four copayment quarters. Thus, despite the $1 saving to the State for most visits, this explains the small differential in total expenditures.

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Mr. Rogers. Mr. Heinz.

Mr. Heinz. Thank you, Mr. Chairman.

Mr. Woodcock, I was quite impressed with the statistics that you presented toward the end of your testimony regarding the costs that would be saved by H.R. 21. You have told us that it would be possible to save some $11.6 billion in cost which would otherwise occur, as a result of doing nothing, and you indicate that system reorganization would encourage concomitant savings in hospital utilization and provider costs which results from the team approach to the delivery of comprehensive benefits. Using this rationale, could you tell us how are we going to save $1 with that, with the approach that you advocate here?

Mr. Rogers. Mr. Woodcock, I think all of us know that your colleagues may want to answer, too.

Mr. Woodcock. Yes.

Mr. Rogers. Whatever you desire.

Mr. Woodcock. I can assure you, Mr. Chairman, they have no hesitancy in doing so when they think I am not doing adequately.

Mr. Rogers. I did not mean to imply that.

Mr. Woodcock. I understand, sir.

Mr. Rogers. They are certainly welcome to offer any comments they may have.

Mr. Woodcock. When Mr. Weinberger was Secretary of HEW he commissioned a study to be made and the apparent purpose of the study at that time was to show that health security was the most expensive proposition facing the Congress. And so our committee actuary took the same methodology that the Weinberger study had used, including the assumptions that they made, some of which we had some questions about, and ran them out over a few years. I emphasize using the methodology and assumptions of HEW, and the numbers that are quoted in this testimony are the results of that extrapolation.

Mr. Heinz. I am trying to get down to a more basic level. You say we are going to save money. I believe that means that we are going to save money in the Federal budget, but where, for example, are we going to save it from? Will we take $2 billion in fringe benefits from the Volunteer Army? Will we take $200 million from the health manpower program because we do not want to encourage the people to go into general surgery on Park Avenue?

I am asking where does the $11.6 billion that you refer to come from? It has to come from something or someone or some hospitals, some part of the existing health care system. Where does it come from?

Mr. Woodcock. First of all, this, of course, is not a reduction of the dollars we are looking at now. There would be less of an inflation impact in health security, this study shows, than there would be in the others.

Mr. Heinz. I understand that you are talking about projections 5 years in the future?

Mr. Woodcock. It would be accomplished through budgeting, through prospective bargaining with the providers in the regions and in localities and elimination through this budgetary system of costly duplicative equipment, for example, services and the rest of it, and with an increasing emphasis on preventive care.

Mr. HEINZ. It may be that it would be helpful, if this is possible, to develop a little tighter flow chart, if you will, of where that money would have gone, that it will not go, if H.R. 21 were enacted. Let me ask——

Mr. GLASSER. May I answer that?

Mr. HEINZ. I do want, like Mr. Scheuer, to get one other question on the record, I am sorry. That is this.

Clearly, all of us in Congress are very conscious of the cost of any program. We have seen programs that we have enacted become much more costly. You presented, Mr. Woodcock, some excellent figures with respect to the burgeoning costs of medicare and medicaid and, of course, I do not think you could find anybody who voted for either of those programs when first proposed, who would have said there was any chance that the numbers we had today would come true, much less the number you say will come true in 5 years. My question is this.

Under H.R. 21, what do you propose to do if the costs, the budgeted costs of H.R. 21 exceed the amount of money that would be available in the trust fund? How would you deal with that problem? Would you set priorities? Would you introduce copayments? How would you deal with that? How would you set priorities in any event? Either you, Mr. Woodcock, or you, Mr. Glasser, may choose to respond. It is up to you.

Mr. GLASSER. May I answer both at the same time, sir?

Mr. HEINZ. Surely.

Mr. GLASSER. Because I think it is a central question Mr. Heinz asked.

Under the health security program, in advance of the fiscal year, the Health Security Board, appointed by the President, based on last year's expenditures, and a study of expenditure patterns over previous years would set an annual budget for personal health services under the health security program. To that budget would be added a cost-of-living factor based on the increase in the cost-of-living index in that year.

In addition, there would be a small percentage set aside for exceptional emergencies and major disaster in some part of the country and a very small percentage to help to begin to equalize access to services among various parts of the country, and in some there are more problems than others. That would then be allocated by regions on the same basis by the Society Security regions. The Social Security Regional Health Security Offices would then negotiate with the providers on a closed budget basis, the providers being only in groups, that is, the group of maintenance organizations, or the group of individual practitioners who serve, to continue to weigh, but would arrogate in the group, would get together as a group and agree to a sum of money based on this budget in which they provide services to all the members who are either in the individual practice sector or in the HMO sector. The same arrangement would be done with hospitals on a perspective budgeted basis. So it is all closed in, Mr. Heinz. Therefore, based on this formula for the first time, the Nation would have an opportunity to know that these are the expenditures.

Now say you, what if the expenditures run beyond that? Now, basically, they should not if you are based on a budget and everybody agrees to the budget, they are held to that. Due to some catastrophe or emergency or something like that, or shortfall in income, due to high unemployment, let us say, that is the situation, then there would be an opportunity in the subsequent years to make up for that difference in the way in which the tax rate and general revenues are structured, but by and large, short of a major recession, which would cut income considerably, there should not be that contingency.

Mr. HEINZ. May I continue for 30 additional seconds, Mr. Chairman, just to get one question on the record?

Mr. ROGERS. Quickly.

Mr. HEINZ. The one thing I would point out is that we know comprehensive benefit packages are costly and this is one reason why we had to rewrite the Health Maintenance Organization Act. Benefit packages can become unpredictably expensive. There is so much we do not know about the cost of making certain kinds of benefits available. So I appreciate your answers, Mr. Glasser and Mr. Woodcock, but there are so many uncertainties that it is very difficult for me to fully agree that we can budget intelligently for them.

Thank you, Mr. Chairman.

Mr. WOODCOCK. May I say very quickly, Mr. Chairman, again, we look to Canada, which has from our point of view, a satisfactory system and as against our 8.4 percent of GNP, they are spending 6.3 percent of their per capita smaller GNP.

Mr. ROGERS. Thank you.

Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman, and Mr. Woodcock, I appreciate your statement very much.

I might say that the goals and the problems in the existing system that you have outlined are not too far apart from the problem in the delivery system as I see it myself today. The question is, I guess, whether or not the Health Security Act is going to solve those problems rather than imposing that additional demand that I expressed in my opening statement that I have great concern about. And the question of costs, I have that serious concern of cost. I believe the fact that this subcommittee is mostly aware of what the additional costs may be and not necessarily just cost to the Congress and our budget system, and as a member of the Budget Committee, I can assure you I do have a concern for that. But my question more relates to the question of cost-benefit.

We have gone, as your own figures show, from 1968, in the period of 7 years, from $4.54 billion to $118.5 billion, 8.3 percent GNP in 7 years, and I ask the question, has the general state of health of the American public been improved to anywhere near that degree of increase in expenditures?

Now, my impression is, it has not, and I would like to hear from you whether or not you feel that the health of the Nation has improved commensurate with the additional expenditures in health care costs?

Mr. WOODCOCK. International statistics would indicate that against other countries we have declined and——

Mr. HASTINGS. That is a major concern that I share. I have an understanding that UAW has one of the most comprehensive health care insurance programs of any segment of our American society. Am I correct in that?

Mr. WOODCOCK. Yes.

Mr. HASTINGS. The benefits provided. Let me ask you, then, I know your costs, of course, have gone up. Let me ask you have you done a statistical study within your membership to be able to show whether or not the state of health of your membership has increased commensurate with the increases that I know have been provided for your health insurance in questions of mortality, morbidity?

Mr. WOODCOCK. We do not have general studies with regard to the UAW membership as such. There are some studies which indicate under some circumstances health can be improved with a controlled dollar situation.

Mr. HASTINGS. Well——

Mr. WOODCOCK. I might say, sir, that when the consensus was made on medicare and subsequently extended to medicaid it was on the basis of absolutely no interference with the delivery system and aboslutely no attempt to have any cost controls or quality controls.

Mr. HASTINGS. I believe that points up my major concern as we proceed, as a national issue, to determine how best we can assure better health to the American people and we share that goal, I am sure.

My real problem is when I take a look, for example, you mentioned that health care costs in this country have gone up 13.9 percent in the last year, but another figure rather interesting in the area of public deliverance to Federal workers, for example, under the public sector, those costs have gone up 22½ percent, far beyond that percentage in the private sector, and I would want to make sure—incidentally, Blue Cross and Blue Shield and Aetna, which cover Federal workers, will be asking for an increase of 62 percent and 74 percent, respectively, next year for Federal workers. Those kind of cost increases without some assurances that the general level of health is going to be improved are just not acceptable. It points out, of course, the problem and you articulated those with the existing system. I want to make sure we have an understanding, a firm understanding, that in fact, as I begin to suspect, I think Mr. Schauer pointed it out, that perhaps access to more doctors and access to more hospitals and access to more health care perhaps is third, fourth, or fifth in reasons why the American public enjoyed good health, and I believe we have to take a careful look at those other matters of environment, nutrition, and certainly Mr. Scheuer mentioned this, the question more people between the ages of 18 and 28 are killed in automobile accidents than any illness. So the additional expenditure and access to health in itself I do not believe is going to satisfy what is our goal and that is, of course, better health care for all Americans. That is why I say I think we have to take a look at all of these things in one comprehensive package.

You yourself on page 12 say that health security is admittedly evolutionary and it will take time to produce progressive changes but it sees the problem as a whole. That point, I like. But I think we are admitting that without those changes in that system first before the imposition of demand perhaps in fact can lead to a greater catastrophe than in our health delivery system than we currently have today. I hope very much, Mr. Woodcock, we can work with you, we in the subcommittee and this Congress, to develop the kind of comprehensive approach to health care. I appreciate your statement very much.

Mr. Woodcock. I might say, sir, that again pointing to Canada, that now that they have a basic health program in place—by the way, the flooding of the system did not take place there. After an initial 2 or 3 months surge of demand, it leveled off to what was——

Mr. Hastings. Let me make one comment. I met with Minister Lalonde myself and one of the things I observed that perhaps we cannot draw complete comparison between our two countries is that a very small percentage of the Canadians were covered by any form of health insurance prior to the imposition of a national health insurance system. There is an inconsistency there. I think we should be very cautious in drawing direct comparisons.

Mr. Woodcock. All I can say, our 120,000 members and their families in Canada are covered by, were before the change in the Canadian system, covered by exactly the same kind of coverage we had in the United States.

Mr. Rogers. Mr. Preyer.

Mr. Preyer. Thank you, Mr. Chairman.

I thank you, Mr. Woodcock, for a very strong statement particularly pointing up the problems of our medical system and I think that gives us an excellent framework for discussion.

Since you concentrated so hard on the problems, you necessarily did not have time to go into all of the details of your health security program, and I think that is the kind of thing we would like to bring out now.

Mr. Scheuer asked you some questions about the financing of the program, and in the appendix to your statement this is where your answers are on that.

May I call your attention to the first line on total expenditures of fiscal year 1978. I think there is a misprint in there under your bill, is there not, where you have $106 billion? Do you not mean $166 billion there?

Mr. Glasser. May I comment? The thing is this was typed twice. There is not a misprint on half the copies. That figure should read 160.2.

Mr. Woodcock. That is the number we are looking at.

Mr. Preyer. So, from that total expenditures for the first year of the program, with no program total expenditures $142 billion, and under your program the cost is $160 billion; under the administration program $151 billion, and catastropic $148 billion. So in the first year of the program your program would cost more in terms of total expenditures?

Mr. Woodcock. Again, I want to emphasize under Mr. Weinberger's methodology and assumption of total cost, yes.

Mr. Preyer. Then, in 5 years you estimate your program would cost less than any of the others?

Mr. Woodcock. That is correct.

Mr. Preyer. I gather that on the financing your program would be about 50 percent self-financing and 50 percent out of general revenue financing; is that right?

Mr. Woodcock. Yes, sir. That is after the program is in place, it would be that. There would be appropriations for the get-ready period.

Mr. Preyer. I think I understand your cost figures.

Let me shift briefly to the question of preventive services. One of the points you make about catastrophic insurance, and I think your analysis of that is pretty devastating, is that there is nothing in it, really, to reduce utilization, particularly, that there is nothing in that that would lead much to preventive services. Do you think simply financing preventive services will do the job or do you think we should develop some kind of particular delivery mechanisms like maternal and child health centers?

Mr. Glasser. Mr. Preyer, it is our view that we have had these kind of mechanisms through the MCH and CC programs for a number of years. Health care in a family cannot be segmented. Children are parts of families, pregnant women are important, obviously, et cetera. Therefore, in our view, the way to get decent preventive health services is to encourage reorganization of delivery, which we are proposing to do, to cover all members of the family including pregnant women and children, and to encourage all sectors of the health care establishment to provide preventive services in two ways. One, through financing; two, through the Resources Development Fund, which is in the health security bill, which allocates funds each year to develop important programs that are not yet in place in the society.

That Resources Development Fund is a major factor in the bill that would help move the society toward making available preventive services other than on a simple statement we will cover them. There is no use covering them if they are not in place. The health security bill covers them and provides a means of putting them into place.

Mr. Preyer. How much will that cost?

Mr. Glasser. The Resources Development Fund in the health security bill begins at a low percentage point and after it matures after some 5 years, it takes 5 percent of total revenues for the development fund. These revenues are not solely to be used by the Board for preventive services also for the training of scarce-help professionals, also for the development of centers in rural areas and in urban ghettos and for other programs that are essential, that they be in place rather than simply be covered. It is a fund that comes annually from the premiums or from the taxes that is used for the development of scarce resources.

Mr. Preyer. If I have a chance for one more question, let me shift to long-term care.

Does your plan assume that medicaid would continue as a Federal-State matching program to pay for long-term care services?

Mr. Glasser. Our plan assumes that most, if not almost all of medicaid would disappear. In those few States, and there are very few today, which have benefits or coverage more extensive than the health security program, it might well be that those States would elect to continue those supplementary coverages; but basically, we would say by and large, most of medicaid would disappear on day 1 of this program.

Mr. Preyer. Thank you.

Mr. Glasser. Incidentally, we should add, all of medicare would be merged into this program.

Mr. Preyer. Thank you.

Mr. Rogers. Mr. Florio.

Mr. Florio. Thank you very much, Mr. Woodcock.

What I would like to do is ask my three questions. I do not think you are going to be able to answer them in great detail but if your staff would be in position to forward a response to me, I would appreciate it. The first point, I suppose perhaps the most broadest, I think most reasonable people realize we do need a comprehensive integral universal system. I sympathize with the points you made with regard to what you refer to as incrementalism, the bandaid approach, being unsatisfactory because by definition, it is not going to provide the comprehensive reforms, but I suspect there is probably a distinction between incrementalism as you define it and an approach which would see a reformed cost control system, comprehensive system put into effect and enacted into law, and yet call for a phased-in implementation of that plan.

Do you contemplate that this is something that is feasible, enactment of a comprehensive plan but as of day 1, it does not go into effect, it would be staggered or phased in in terms of cost and terms of coverage?

Second point. I think it is very commendable that you are dealing with mental health, it is a serious problem in this country, and yet I am wondering what cost controls you see as being available to deal with essentially a subjective illness in many respects?

And the last point I would like to make is that if for some reason or some way we could have this program go into effect tomorrow, are you at all concerned about the inadequacy of our personnel standards, our health personnel standards in this country, that is to say, is it not conceivable we could have the program and through some of our problems, maldistribution geographically, geographic or maldistribution with regard to specialty, we would not have the health personnel necessary to implement and carry out the provisions of the bill?

Mr. Woodcock. Mr. Chairman, let me say that some of the questions raised by Mr. Scheuer, we have not adequately answered and we will in writing respond to all of these.

[See "Questions ______," p. 23, this hearing.]

First, with regard to the difference between incrementalism and phasing in. We see it as a real distinction there and the principles that are outlined on page 13 of our statement say what we would from our point of view insist upon in any bill. But beyond that we are obviously not set in cement on the goals to which we go. So we draw a distinction between something that says OK, we will do this much now, and entirely related to the total problem, and then maybe 5, 10 years from now we will come back to the total problem. Because that is one thing. It is another thing to make the national commitment and then say, OK, for these reasons it will be over time.

Mr. Florio. Sir, could I ask on that point, realizing that tactically it probably would not be wise for anyone who advocates this bill at this early stage, to come in with plan 2, that is to say, an alternative bill that provides for the adoption and statutory phasing in, it probably would not be wise to give that away at the outset. From a tactical standpoint, are you prepared or do you know anyone that is prepared to come up with some legislative proposals to that effect, that is to say, if the Congress should not see fit to enact H.R. 21 because they do not want to see the instantaneous or immediate implementation of the full plan tactically, it may be of some value to have some plan 2 available so a program could be adopted with the understanding that it would not be immediately implemented, it would be a phased-in approach?

Mr. Woodcock. Since H.R. 21 in essence is an evolutionary process, obviously, the sorts of things I indicate are possibilities. But I find myself in the same difficulty General Motors, Ford, or Chrysler say today, that is, this is what you demand, what do you really mean when you say, OK, we expect to get over there, that is where we start. And that is why I restrained myself to generalities. Would you talk about the mental health?

Mr. Glasser. Yes; briefly, I can respond very briefly on your mental health question. The UAW 11 years ago negotiated the first nationwide out-of-hospital and in-hospital psychiatric benefits. The pattern that we developed, which was, namely, the treatment through short-term therapy and not character reorganization out of the hospital and adequate in-hospital coverage has demonstrated in 11 years an economically viable program that is increasingly used by the membership. Based on the statistical and actuary experience in that program, the benefits written into the health security program reflect that. We believe we have substantial evidence to indicate (a) that the benefits in this pattern of design will not be overly utilized because we do not cover character reorganization, and (b) will, over time, not escalate unduly.

For example, our mental health benefits have not escalated at nearly the rate of our general medical benefits.

Mr. Florio. Realizing my 5 minutes are probably up, could I ask, in answer to the last question, if the existing health manpower facilities and resources in this country are sufficient to sustain this program, to support this program if it were to go into effect today?

Mr. Glasser. Initially there would be problems but fewer problems than we have today, but the system and the program has built into it legislation in a dozen different points, means of providing for evolutionary change with the resource distribution. We have no question, no question there would be shortages but there also is an immediate trigger mechanism to begin to deal with them.

Mr. Florio. Thank you.

Mr. Rogers. Mr. Waxman.

Mr. Waxman. Thank you, Mr. Chairman.

Mr. Woodcock, I, too, want to express my appreciation for an excellent statement and for the work that your organization has been doing to bring to the American people some kind of comprehensive health insurance program. So many of the questions that have been asked dealt with the substance of this program and the very critical issues that are before us. Let me now ask you a procedural question. There are two subcommittees of Congress holding hearings on national health insurance, two on the House side. It seems to some that this division of jurisdictional authority has been a major block to moving forward on comprehensive health insurance. Noting your very kind word about this subcommittee's work in setting up an infrastructure development of a comprehensive health insurance program, what thoughts do you have, if any, about the way we ought to proceed in order to resolve the jurisdictional dispute and thereby move forward in adopting an insurance program, a program which so many of us promised the voters that we would work for?

Mr. Woodcock. Well, obviously, both committees have a role to play in this and since we are convinced—when I used to come down here on the energy problem, I would be told so many times the American people had not made up their mind, so we cannot make up our minds. Poll after poll, Gallup, Harris, Cambridge report, you name it, have said on this, the American people have made up their mind, and I would hope that as against a national consensus the jurisdictional problems that the Congress has cannot stand in the way, and from our point of view, we think both committees have a meaningful role to play in the resolution of this question.

Mr. Waxman. I see. Granting your statement that the American people do want us to move forward, do you think that the split in jurisdictional authority is a major roadblock?

Mr. Woodcock. It has tended to be to this point; yes, sir.

Mr. Waxman. And do you have any suggestions on how that roadblock might be removed?

Mr. Woodcock. Well, I would think that people of good will could find a way around it.

Mr. Waxman. Substantively on the issue of health insurance programs, all national health insurance programs involve to some extent, or to a great extent, the redistribution of income. You have noted that in the catastrophic health insurance program the poor people and the lower income people would be subsidizing the wealthy.

How would you characterize the redistribution of income effect of the program that you are offering to us today?

Mr. Glasser. The health security bill would move modestly in the direction of income redistribution in that when you have payroll taxes on 100 percent of payroll on the employer and up to $21,000 in the present health security bill, that number probably should be higher because the bill was written some time ago. That begins to become more equitable since it covers the incomes of most people and enables those on the lower end of the scale to get into the system and into the mainstream of the system paying relatively less in terms of income. In addition, it must be remembered that there are 40 million Americans under the age of 65 who have no private insurance coverage whatsoever. Putting them into the system and giving them the advantage of the benefits of health security begins in a major way to provide for income redistribution for those people.

Mr. Waxman. Do you think that the use of the payroll tax is a regressive vehicle for financing a program that ought to be financed through some progressive form of taxation?

Mr. Glasser. There are two comments on regressivity. Regressivity is usually considered in terms of the present social security system with its present ceiling. The health security program has a much higher ceiling on income.

Second, things in terms of regressivity is in relation to benefits. Our experience has been and continues to be that those on the lower income and end of the income scale get proportionately more benefits than those on the upper income scale in terms of health needs. Their needs are greater and, therefore, we believe health security, while it is by no means the panacea in income redistribution, has as little regressivity as any proposal before the Congress, less than any before the Congress. The most regressive measures are those measures sponsored by the AMA and health insurance industry. Those are the most regressive in terms of mandating employer-employee concern with 35 percent payment by the employee.

Mr. Waxman. Thank you very much.

Let me comment that I am looking forward to your written answers to some of the other questions that have been asked. I think that many of these address the major issues before us.

Mr. Woodcock. If the only problem before us to getting H.R. 21 adopted was the revenue had to come entirely from general revenue, we would yield gracefully on that point.

Mr. Rogers. Thank you.

Mr. Hefner.

Mr. Hefner. Thank you, Mr. Chairman.

Mr. Woodcock, we would like to thank you for a very comprehensive and enlightening statement.

I have mentioned what I thought about national health insurance when people ask me during a campaign or meetings. I have often given the answer that we should come up with something we can afford and something to guard against catastrophe for our working people. But here is a statement you make that is staggering to me: catastrophic health insurance has deductibles of 60 hospital days and $2,000 in physician's fees. This would be a real catastrophe for the average man before his insurance coverage would be triggered. He would face a catastrophe even before his catastrophic insurance came into play. And you say that 99.5 percent of the American people would not even be protected under such a plan as this. Is that correct?

Mr. Glasser. That is correct.

Mr. Woodcock. That is our estimate. Less than a million people, all told. Those are the specifics of the Long-Ribicoff bill on the Senate side.

Mr. Hefner. In another area I notice that there is going to be a great amount of controversy with the carriers, the insurance companies. I believe you testified that Mr. Weinberger said 300,000 people would be put out of work if we enact a national health insurance; is that correct?

Mr. Woodcock. Mr. Weinberg said, if health security were in place, we would need from 43,000 to 49,000 additional governmental employees. The chairman of the Equitable Life Assurance Society of the United States said that we would lose 300,000 in the private sector.

Mr. Hefner. Let us cover this. Where, in the Secretary's opinion, would these 45,000 to 49,000 people be required?

Mr. Woodcock. These would be mostly in the local and regional offices.

Mr. Hefner. To administer this new plan?

Mr. Woodcock. Yes, sir.

Mr. Hefner. All right; the Equitable people say that there would be up to 300,000 jobs lost. What area would these come from?

Mr. Woodcock. These would be sales people, administrators and all the rest that are involved in what are in the neighborhood of 1,800 private plans now in existence.

Mr. Hefner. Relating to the situation in Canada, I believe you testified that in 1969 for every $1 paid out there was $1.25 collected; is that correct?

Mr. Woodcock. Yes, sir. That was what Minister LeLonde said in the speech, I think, here in Washington. He is the Minister of Health of the Federal Government.

Mr. Hefner. Since the new plan is in place in Canada, for every dollar paid out there is $1.03 collected; is that correct?

Mr. Woodcock. That was the Minister's testimony, not testimony, but that is what he said in his speech; yes.

Mr. Hefner. What do we have in this country on health programs? For every dollar collected, what is the expenditure? Do you have any statistics along that line?

Mr. Woodcock. Well, in general, on the private——

Mr. Hefner. In the private sector.

Mr. Woodcock. On the individual health insurance policies, for every dollar paid in premiums, they get back only about 50 cents in benefits.

Mr. Hefner. What, in your opinion, would be the impact on private industry for health programs for the average worker in a textile mill that had a group plan? If we had a national health insurance, what would be the impact on private industry, and on the insurance industry?

Mr. Woodcock. Well, we, of course, have done precise studies with regard to the employers with whom we would deal, we do deal. They would save money if health security were in place based upon the financing proposed in H.R. 21. So I am sure the same thing would apply to any company.

Mr. Hefner. They would save money?

Mr. Woodcock. They would save money; yes, sir.

Mr. Hefner. Would they not in essence be out of the business of supplying insurance to groups? How does the private industry figure into the national health insurance?

Mr. Woodcock. When you say the private industry——

Mr. Hefner. Like Prudential, Blue Cross.

Mr. Woodcock. Obviously, in that sector of their activity, which certainly is not an overriding sector, they would have a lesser role to play.

Mr. Hefner. I thank you.

Mr. Rogers. Mr. Maguire.

Mr. Maguire. Thank you, Mr. Chairman.

I do not want to take too much time, Mr. Chairman, other than to say that I want to thank Mr. Woodcock for his excellent statement.

I think it is clear to all members of the subcommittee that we have come to the point where we must have some legislation that provides for adequate health care for all Americans in this country, and I hope that we will move rapidly toward the development of a proper and comprehensive piece of legislation, Mr. Chairman.

Mr. Rogers. All right.

Mr. Woodcock, let me ask just a few questions, if I may.

Under your proposal, if this bill were to be enacted into law in 1976, the tax requirements would go into effect as of when?

Mr. Woodcock. There would be a 3-year lead-in time. It would be fiscal 1979.

Mr. Rogers. It would be 1979, January 1979. Your benefit packet would come into effect as of when?

Mr. Woodcock. It would begin in that same year but 6 months later.

Mr. Rogers. July 1979.

So if the Congress enacts a bill at this time you would anticipate some leadtime before the program actually began to function?

Mr. Woodcock. Yes, sir, except the resources development fund which has been described, would begin immediately with general appropriations as support.

Mr. Rogers. It would be supported by general appropriations, not from social security taxes?

Mr. Woodcock. In the first 2 years, $200 million in the 1st year, the 2d year $400 million, according to the bill's specifications now.

Mr. Rogers. Who would set the priorities for your resource development fund? Is that done by the board?

Mr. Woodcock. The health security board; yes, sir.

Mr. Rogers. And who do they rely upon?

Mr. Glasser. The health security board has its own staff and in addition to depending on the regional staff there will not be any to start with, obviously, but the initial priorities would be set by the Board with its staff in the direction of the development of a national health policy, which is No. 1 on the agenda, as we all know does not exist.

Mr. Rogers. What I was thinking about was facilities. How will that newly formed board set priorities for the Nation as to which hospitals should be built, or which outpatient clinics?

Mr. Glasser. I see.

Mr. Rogers. I presume that is what you are anticipating?

Mr. Woodcock. That is what we meant in our testimony. Fortunately, you have put an infrastructure into place in terms of planning.

Mr. Rogers. Health planning?

Mr. Woodcock. It would be the intent of the health security board to use that mechanism.

Mr. Rogers. I wondered why you transferred the authority from health planning to the security board?

Mr. Woodcock. Well, the major policy is set federally but then on the regional basis and on the State basis the allocation of funds is determined by negotiation with the providers and those negotiations are dependent on the priorities and the decisions made by the HSA's which hopefully, will be fully operative within the next year.

Mr. Rogers. Now, who sets the priority within the State?

Mr. Woodcock. The priority within the States is set by the regional health security board. There are regions just as there are social security regions, based on the existing agency, PSRO and HSA.

Mr. Rogers. I do not think a PSRO would have much to do with resources facilities. I think we need to get into some detail in this. I will not pursue it now, but I think there are some problems here that need to be discussed further.

Let me ask you this: I am interested in services. As I understand it, physicians services—other than psychiatric, and that is even suplied in a certain amount—would be provided in both an inpatient and outpatient basis; is that correct?

Mr. Glasser. Yes.

Mr. Rogers. All major surgery would be included?

Mr. Glasser. All major surgery would be included, yes, sir.

Mr. ROGERS. What is the relationship of your catastrophic coverage to major surgical expenditures? Is there any determinative factor there?

Mr. GLASSER. In our judgment, Mr. Chairman, this would not be needed because this would be a medical decision and if it is medically determined that surgery is required it would be paid for.

Mr. ROGERS. Then, is there any need to have separable catastrophic coverage in your bill, since you are giving coverage throughout?

Mr. GLASSER. The basic answer is, no. The basic answer is, no.

Mr. ROGERS. The system would pay for the bills anyhow, so you would have catastrophic coverage inherent in the bill.

I noticed in your testimony that you made a point that you provide catastrophic coverage.

Mr. GLASSER. We needed to make that.

Mr. ROGERS. I am not sure I understand that classification.

Mr. GLASSER. If you please, sir, we needed to make it to make precisely the point you have made, because people are not fully comprehensive to the fact that this is a basic bill that covers all services.

Mr. ROGERS. Now, as a matter of fact, I am not sure that this bill reduces catastrophic costs any more than any other bill—services have to be paid for. However, I understand that you feel that there is some element of hope as far as holding down inflationary costs—similar to the role played by PSRO's, utilization committees and so forth. Is that to be the function of the overall budget?

Mr. GLASSER. Overall budget, perspective budget for hospitals.

Mr. ROGERS. Let me ask you——

Mr. GLASSER. And for providers.

Mr. ROGERS. As I undertand it, this perspective budget is to be determined by the Board through its regional people. How do the provider and the consumer get into that budget process, or is it just done by the Board with some advice from the region? In other words, how are you making decisions like how you are going to pay a doctor—by capitation, by fee for service or by a prepayment plan?

Mr. GLASSER. Let us take the Federal level first. On the Federal level the budget is determined on the expenditures of the previous year plus cost-of-living with an analysis of trends. Actually, the trends have been very consistent over the years. So that you have a built-in figure and there is a Consumer Advisory Council at the Federal level which advises and participates in the way this is set, but this is not on open ended budget, it is based on this formula. Then, allocations are made again with the Advisory Council participating to the regions based on the same formula with the two modifications to which I referred. One, the possibility of a disaster in the area; (2) a beginning redistribution of resources to the lower users, let us put it that way, the poorer medical areas of the country. Again, at the regional level there is a Consumer Advisory Council that participates in that determination.

Now, once the formula is set as to what the outer perimeters are, the negotiations with groups of providers are conducted by the officials of the Government in the region with the groups of hospitals, the groups of doctors in solo practice, the HMO's. Those are the three primary groups.

Mr. ROGERS. A region represents what part of the country?

Mr. GLASSER. Identical to the social security regions, they are identical.

Mr. ROGERS. So that you would have how many regions?

Mr. GLASSER. Ten.

Mr. ROGERS. Now, are you saying that all of the doctors of one State send a representative to the State and they negotiate?

Mr. GLASSER. Yes; it is not individual doctors, sir. Let us say, there is a region and the region is Chicago and the State is Indiana, if you please. The doctors in Indiana, these are solo practice doctors. Solo practice doctors in Indiana would determine for themselves who would represent them in terms of determining the budget for the coming year.

Mr. ROGERS. How do they do that?

Mr. GLASSER. They do that by election. They can elect to use the Blue Shield system, a private insurance company, or their own medical society if they prefer.

Mr. ROGERS. To negotiate?

Mr. GLASSER. To negotiate in their behalf.

Mr. ROGERS. Is it advisable for them to form a union?

Mr. GLASSER. They could if they wished, but the purpose of this is to negotiate an overall budget.

Now, the second part of this is how does the doctor get compensated, the solo practice doctor?

Mr. ROGERS. Let us not proceed there yet. I might say I am taking my 5 minutes first in the second go-around, if I may, since I was here first.

I just want to understand. I think it is very important for us to understand these processes.

All right, you have some individual practitioners, they want to be paid on a fee for service basis. Another group says, we will go with the prepaid method of payment. Suppose the charges are different there? They say we are not going to do an appendectomy for the same fee, you can get care and everything else?

Mr. GLASSER. That is why I was trying to go to the individual doctor, Mr. Rogers. All the doctors in Indiana, the State I selected for illustration, who determine that they wish to remain in the solo practice system, and we expect the overwhelming majority initially will.

Mr. ROGERS. Choose fee for service?

Mr. GLASSER. Yes; I am not going to say that for a moment, yes. All those who wish to remain in the solo practice system select one of the alternatives to represent them. They negotiate a budget for the people that they will serve for 12 months and they must agree to remain with the constraints on that budget. It is based on the expenditures for these people last year.

Mr. ROGERS. For each individual?

Mr. GLASSER. No; for the group.

Mr. ROGERS. How does the group get that figure?

Mr. GLASSER. The groups, let us just——

Mr. ROGERS. From individual practitioners?

Mr. GLASSER. We know what the expenditures are, not by individual practitioners, but we know what they are by the whole group. We know what is expended for out-of-hospital care, for physicians services in Indiana last year and the year before that.

Mr. Rogers. How do we know?

Mr. Glasser. We know that from the experience and the figures that the Social Security Administration and the insurance industry have collected over many, many years. Mr. Rogers. But that is just part of the story. Some of the people who go to doctors do not even have insurance. Some may pay out of their pocket. In other words, I am not sure that we are closing that gap.

Mr. Glasser. I believe, sir, that we can quite readily put together information on a State-by-State basis.

Mr. Rogers. Does this mean then, that a doctor cannot take any new patients because they are not in his budget?

Mr. Glasser. No; it means this, if I might complete the cycle. The physicians in Indiana have their representatives, whether it be an insurance company or a foundation or Blue Shield, represent them. They negotiate a budget and agree that for those patients who are elected into their system they will cover the entire expenditures for 12 months. Now that budget should be adequate based on what happened in the year and the year before, plus a coat-of-living factor. Those physicians then will then determine how they wish to be compensated. They will decide whether they want fee for service, fixed fee schedule, capitation. They can do it any way that they determine with only one proviso, and that is for those people for whom they have contracted they will provide the medical services for 12 months.

Mr. Rogers. That almost is a prepayment for each individual then?

Mr. Glasser. It is a prepayment for the group of individuals as well as the group of providers.

Mr. Rogers. So it is a prepayment in effect through a budgeting process which says to the provider that you should keep your medical practice within a set amount.

Mr. Glasser. Not as an individual. We say to the entire group that is the way it is and you please yourselves in terms of the escalation of costs. If you want to pay on a fee for service, so be it. If you want to pay on capitation, so be it.

Mr. Rogers. You are telling me all individual practitioners must come together as a group?

Mr. Glasser. That is correct.

Mr. Rogers. So there is no individual practitioner as such, he must belong to a group?

Mr. Glasser. He must belong to the group that represents his economically, as he does not with Blue Shield.

Mr. Rogers. His payments also come to him through the group?

Mr. Glasser. The payments come to him from group just as they do now through Blue Shield. When we are talking group we are not talking about a practicing group, we are only talking about a budget group. We are not saying all the doctors in Indiana practice together but as they do in Indiana today they are paid by Indiana Blue Shield for those who are covered. They would be paid by their representatives if it were——

Mr. Rogers. As though right now they projected a cost of what they could deliver care for under medicare, for instance; they would have that budget, as I understand it.

Mr. GLASSER. Yes.

Mr. ROGERS. For all their patients?

Mr. GLASSER. That is correct, except under medicare there is an open end.

Mr. ROGERS. Except that under medicare we only pay 80 percent of the costs, do we not?

Mr. GLASSER. Yes, sir.

Mr. ROGERS. Of the reasonable cost?

Mr. GLASSER. Of open ended.

Mr. ROGERS. Well, what closes it? That is what I am not clear about. I am not sure how your plan closes the end because, as I see it, they might put into their budget the full cost of medicare, not 80 percent.

Mr. GLASSER. Mr. Rogers, they might put it into their budget but under the health security program the maximum allowable for the coming year will be the total expenditures of the year before the health security program went into effect plus a cost-of-living allowance.

Mr. ROGERS. Where is that controlled? How does that change come about?

Mr. GLASSER. The change comes about——

Mr. ROGERS. You only set the limits from the time your plan is enacted. The only increase allowed then, as I understand it, is the cost-of-living?

Mr. GLASSER. That is correct; and the other way in which the provider income could be increased is if he increased the number of his patients, or if he changed the way in which he worked. But basically, it assumes——

Mr. ROGERS. In other words, we zero in and hold steady——

Mr. GLASSER. Precisely.

Mr. ROGERS [continuing]. Everything that is paid now. Suppose it is too much now, what we are paying?

Mr. GLASSER. We believe——

Mr. ROGERS. Is there any mechanism to get to that?

Mr. GLASSER. We believe it is too much. We do not propose, however, to turn back the clock. We think it is too late.

Mr. ROGERS. Even in some areas where there may be too much?

Mr. GLASSER. There is an answer to that because with this kind of budgeted constraint the physicians are going to have to police themselves, and if in fact physician A is getting far more than he should out of the system, he is going to get it at the expense of physician B. Now he gets it at the expense of the general system.

Mr. ROGERS. If I come in to see a physician, he says you are not in my budget, what do I do?

Mr. GLASSER. The point is that you are not on an individual physician's panel. There are no physician panels under the system.

Mr. ROGERS. I am not talking about a panel. I am saying I am a patient.

Mr. GLASSER. That is right.

Mr. ROGERS. I go to the doctor of my choice. I say I have got some problem here, I want you to take care of me. He says I cannot take you, you are not in my budget. You forgot to come see me last year; you will have to go back to Indiana where you were covered.

Mr. GLASSER. Mr. Rogers, the physician would be paid for each of the patients he serves so that the number he had for last year does not necessarily have to be the number for this year, because there is not an individual physician, there is not an individual physician budget, there is a group of physicians' budget.

Mr. ROGERS. But suppose the group of physicians says you have already hit your budget.

Mr. GLASSER. There is no individual budget. The group can only say to you, if you were part of the group, we will pay you so much per service, so much on a capitation, whatever basis they determine.

Mr. ROGERS. Well, suppose they are getting to the last of the year, they are committed to a certain budget level and they are running out of funds. We know they have this committee; what happens?

Mr. GLASSER. Then the entire group, the entire group which has overexpended, they would be knowing from month-to-month whether they are meeting their goals, you would not wait for the very end.

Mr. ROGERS. But in Florida many more might come in in one month, when we have visitors in the State.

Mr. GLASSER. Except, sir, that you have had visitors for 50 years.

Mr. ROGERS. I know some years it is down and some up hopefully, this year it will be up.

These are just questions I think we need to explore.

Mr. GLASSER. This would be provided for, this is part of the regionalization I mentioned. But actually, to answer your question, finally, if at the end of the year, let us say, in the last month, they were short, they would be paid on a pro rated basis.

Mr. ROGERS. Mr. Scheuer.

Mr. SCHEUER. Mr. Woodcock, throughout your testimony on pages 6, 15, and 16, you make various criticisms of the role that the insurance companies have filled, their absence of oversight on costs, their absence of oversight on quality care, their absence of oversight on utilization of hospital beds, on utilization of drugs, unnecessary surgery and the like.

I wonder, since I am a freshman member of this committee, and have a very limited knowledge of all these areas, whether you would do me and the only freshmen members the courtesy of giving us a memo on the role of the insurance companies. Could you just give us your perception of the role that they have played, documenting it with the appropriate facts and statistics.

You mentioned, for example, on page 6, that they are retaining $4 billion for operating expenses and profits. That is $4 billion out of how much that they collected? You say they collect a major share of the estimated $8.9 billion but I have trouble——

Mr. FINE. Out of about $30 billion, Mr. Scheuer.

Mr. SCHEUER. Thirty?

Mr. FINE. Thirty.

Mr. SCHEUER. Thirty?

Mr. FINE. Thirty.

Mr. SCHEUER. That is something like 12 or 13 percent. So, it would be fair to say that in Canada the cost of administration amounted to about 3 percent, whereas the cost of administration for the insurance companies would be something like 12 or 13 percent?

Mr. FINE. Of course, it varies between the Blues on the one hand and the commercial companies on the other. We will give you a paper on that.

[See "Questions____," p. 23, this hearing.]

Mr. SCHEUER. This is exactly the kind of thing that——

Mr. WOODCOCK. May I say with regard to the Canadian number, $1.03 as against $1, that was taken from the speech of Minister LeLonde.

Mr. SCHEUER. $1.03 as against $1?

Mr. WOODCOCK. Our projections of administrative costs of health security are a higher number than that.

Mr. SCHEUER. Are they higher than $1.25?

Mr. WOODCOCK. No, no, than the 3 percent, that is correct.

Mr. SCHEUER. Do you mean under our social security?

Mr. WOODCOCK. No, no, our estimates of what the administrative costs would be if health security were in place.

Mr. SCHEUER. These would be higher than 3 percent?

Mr. WOODCOCK. Yes, sir. Not a great deal. Our numbers have been in the neighborhood.

Mr. SCHEUER. Is it diseconomy of size or diseconomy of being American rather than Canadian? Do they know more about computers than we do? To what do you attribute this?

Mr. WOODCOCK. No; because the system we contemplate is one of evolutionary change, whereas in some of the provinces in Canada they have had a longer time span of adjustment, so they would have started when they went into effect, they started from a different base than we would be starting.

Mr. SCHEUER. Thank you. Now let me get back to the business of your advocacy of the payroll tax. I do not mean to appear as if I had an acute case of tunnel vision, but this is important to us, as you understand. If New York City came up with a sales tax on food and on clothing and on medicine, as a way to finance its way out of the morass it is now in, you would call that a regressive tax, would you not?

Mr. WOODCOCK. Yes.

Mr. SCHEUER. You propose to place a tax on food and on clothing and on the cost of medicines as away of financing a health care system, when it seems to be our feeling that the most progressive way of financing health care is through a graduated income tax. You not only would tax food and clothing and medicine to finance a national health system, but you would also exclude all incomes over $20,000 a year, or $21,000 a year, from contributing to the cost of that national health system.

How does that fit into your record over generations, in supporting a progressive tax system to produce the revenues for needed public and social services?

Mr. WOODCOCK. Well, the bill provides for 1 percent upon the payroll taxes of the individual worker up to a ceiling of $20,000.

Mr. SCHEUER. Would that include workers in the food industry?

Mr. WOODCOCK. In all industries.

Mr. SCHEUER. The clothing industry?

Mr. WOODCOCK. All industries.

Mr. SCHEUER. Medicines?

Mr. WOODCOCK. All industries.

Mr. SCHEUER. So you are increasing the cost of food, clothing and medicines as a means of financing a national health care system?

Mr. Woodcock. No; because they are currently paying nine-tenths of 1 percent for medicare, which would be washed out. It would be an increase in effect, of only one-tenth of 1 percent.

Mr. Scheuer. You are increasing all these costs with a direct and regressive tax to support your system of national health service, are you not?

Mr. Woodcock. By one-tenth of 1 percent, yes, except that would be clearly——

Mr. Scheuer. Plus the tax on employers, which is also added to the cost of food and clothing and medicine, is that correct, all passed on as cost of the product that is on the shelf?

Mr. Woodcock. Except, sir, they are paying that and more for the present system through the private means.

Mr. Scheuer. I am not suggesting we freeze into concrete all of the inequities of the present system. What I am suggesting that to the extent Government funds are needed to finance a national health system, collecting those funds through a progressive tax system, is the most equitable and fair way; and that by your advocacy of a regressive tax system—one that will increase the cost of food, the cost of clothing, the cost of medicines, and that would exclude all incomes over $20,000, you are departing from the standards that you have held high to the American people about tax progressiveness, tax fairness and tax equity. I am at an absolute loss to understand why you are doing this.

Mr. Woodcock. Sir, it is not inconsistent. This is already being paid by employers. It would not increase the prices of their product because it would decrease the cost to them.

Mr. Scheuer. I do not understand it.

Mr. Woodcock. Because they are paying more than that, sir, through the private system now today. That cost increase averages 13.9 percent and more in some cases. This is just a change of dollars.

Mr. Scheuer. Whatever the faults of the present system are, we will try and evaluate them and analyze them and eliminate them. Concerning the future, we do have to raise funds to support a national health system. I still cannot understand why you are chosing a means of financing that health system that is in theory and in practice regressive.

We do intend to do something about those private sector costs. Whatever the costs to the Government are to finance a national health system, why do you not stand by your guns of 40 years and rely on a progressive income tax system that taxes income all the way up to the zillions, that does not exclude incomes over $20,000 or $21,000 a year, and that does not add to the cost of food, clothing, and medicines? I cannot understand this theoretical inconsistency between your position today and your position over 40 years of advocating sound, just and equitabl tax programs.

Mr. Woodcock. Well, sir, we are faced with a situation where 40 million Americans are entirely outside of the health care system.

Mr. Rogers. And we think they ought to be covered. You are not going to cover them by a payroll tax.

Mr. Woodcock. Every time I have testified on tax reform before the House Ways and Means Committee and the Senate Finance Committee, I have pointed to the gross inequity of 5.85 percent from the first dollar earned for Social Security. Quibbling about 1 percent over here, which is an exchange for the present nine-tenths of 1 percent they are paying, let us have a corridor on the Social Security tax which is six times as high. That would give the help to the people who are in the lower middle income and the low income groups.

Mr. SCHEUER. I still do not understand why you are not ready to rely on the most progressive system for raising money that our country has ever devised, namely, the Federal income tax.

Mr. WOODCOCK. Because, Mr. Scheuer, we have been coming down here crying for reform in health care.

Mr. SCHEUER. Why are you not crying for us to reform the method of payment?

Mr. WOODCOCK. We are always told where is the money coming from, Mr. Woodcock, the Federal budget cannot bear it.

Mr. SCHEUER. Yet you are not saving any money by going to a payroll tax, you are just making it more regressive. You would save money by——

Mr. WOODCOCK. We are saving some impact on the Federal budget. I repeat, how we finance it is a small——

Mr. SCHEUER. You are not saving a penny on the Federal budget. That is just a bookkeeping ledger. Dollars that we spend are dollars that we have to raise, and the most equitable way that we can raise funds from the public, the working public, the retired public, the disabled public, is through the Federal income tax, which is a theoretically fair and just instrument because it is progressive.

Mr. WOODCOCK. I repeat, sir, that if that is an offer, we will take it.

Mr. SCHEUER. I do not want that to be a lackluster unenthusiastic acceptance, I want to know from you what you think is right.

Mr. WOODCOCK. Because this Congress——

Mr. SCHEUER. Do not talk about this Congress.

Mr. WOODCOCK. I have to talk about this——

Mr. SCHEUER. This is the Health Subcommittee.

Mr. WOODCOCK. I have to talk about this Congress. This Congress which has wrapped itself into a miasma relative to the size of the Federal budget when the national debt has been coming down as a percentage of our Gross National Product when I am told we cannot go above this magic number, we cannot do our job with this Congress, where is the money coming from? Where is the money coming from?

Mr. SCHEUER. You are testifying right now before the Health Subcommittee of the Committee on Interstate and Foreign Commerce, and we want your best judgment as to how to finance a national health program. Let us worry about the rest of the Congress. That is what we are paid for. We will take this to the full committee and then we will take it to the floor. We want our legislation to include your best judgment as to what is the most fair, equitable and decent way of financing national health care.

Mr. WOODCOCK. All I know, I have been coming down here as president of the UAW and chairman of the HSAC and for over 5 years I have to listen hard for the answering echo. It is my worry about what this Congress does. It is not willing to say it is your worry, it is the worry of the American people, you are a representative government, not a dominating government.

Mr. SCHEUER. We are paid by the American people, we are asking you for your best judgment as to the fairest and most equitable way of financing a national health program, and I do not think we have gotten it from you. I think you have clearly expressed a reservation in what you say, and I want your flat statement as to what is the fairest and most decent way of financing a national health program. Is it or is it not a progressive fair income tax?

Mr. Woodcock. Obviously, if that were to be the fairest way.

Mr. Scheuer. I am asking what is the fairest way.

Mr. Woodcock. I am getting sick and tired, sir, of getting responses from the most liberal Congress we have ever had as to why——

Mr. Scheuer. It is not the 89th Congress.

Mr. Woodcock. Chasing will-o'-the-wisp is the answer to the fact we are not getting any fundamental reform out of this Congress. This is the problem.

Mr. Scheuer. You help us get some fundamental reform. I am saying the most fundamental reform you could advocate would be to support a national health program financed by the Federal income tax.

Mr. Woodcock. All I know is that the people I represent, there are some 5 million when you count the members of the families, are willing to accept this kind of——

Mr. Scheuer. They are?

Mr. Woodcock. They are willing to accept this kind of financing mechanism and the American people have said the only thing that they are willing to pay more tax for is health care as a matter of right. Let us not get all tied up in ideological quibbling.

Mr. Scheuer. This is not ideological.

Mr. Woodcock. This Congress, a certain section of this Congress has made an art form out of ideological quibbling as a response to not doing——

Mr. Scheuer. Mr. Woodcock, you and the AFL–CIO since I was a teenager, have been advocating fair and equitable and responsive responsible tax reform on principles of equity.

Mr. Woodcock. We have not changed our position on the question of tax reform but we are not getting very far with this Congress, are we?

Mr. Scheuer. Well——

Mr. Woodcock. We are not getting very far with this Congress, are we?

Mr. Scheuer. I think this Congress will do its job and we are looking to you for help and support, but I think you are obfuscating the issue this morning. I would like to have you say what you think is the fairest and most equitable way of financing national health.

Mr. Woodcock. I say to you on the question of tax reform, we want a tax cut geared on the middle and offset in the first 2 years by $20 billion of loophole closing, closing the rest in the second and third year. What is the answer we have gotten from the Congress—no?

Mr. Scheuer. We went a little bit of the way in November. We made a little start last week.

Mr. Woodcock. Why do you compromise, sir?

Mr. Scheuer. I did not compromise. I voted for every single one of those reforming amendments to the tax.

Mr. Woodcock. All I know, we have a health care system that is going to hell in a hand basket, if you will forgive the language, and we cannot be quibbling, we cannot be quibbling. The people are willing to accept this kind of financing mechanism.

Mr. SCHEUER. I am not asking you about what the people are willing to accept, I am asking you for your best judgment as to whether the progressive income tax is not the fairest way to finance a national health program.

Mr. WOODCOCK. First of all, the progressive income tax ain't all that progressive any more.

Mr. SCHEUER. We are making it steadily more progressive and we took a little step in that direction last week.

Mr. WOODCOCK. If you wipe out all loopholes put in in the last 6 years——

Mr. SCHEUER. Indeed, we are faced with the conditions and not a theory, as Grover Cleveland said about a century ago. We did not go back last week.

Mr. WOODCOCK. The reason George Wallace has such great appeal to the members of my union, particularly the white blue collar workers, is because they are getting the business in taxes, including Federal taxes. He tells them that. He does not give them an answer but they know they are getting the business.

Mr. ROGERS. I am sorry.

Now, if I may get back to some of the points that I am very much concerned about, in determining the mechanism of how this would work. We began with the private practitioner, we started there first, then we went to the group which would negotiate for them. If the group runs out of money then they could adjust somehow.

Mr. FINE. Pro rate.

Mr. ROGERS. How do you pro rate?

Mr. FINE. We have the finite sum of dollars for that group. If through overcharging or for overutilization, unnecessary utilization, as Mr. Glasser explained, within that group, the control does not apply, does not stop this, and we have every reason to believe it will, then the system would have to pro rate.

If within a group, for example, there were $1 million available for all physician services, and if after a month instead of utilizing one-twelfth of that amount, say it was one-tenth, and the next month again it was one-tenth, the system would have to pro rate the payments for the fees.

Mr. ROGERS. But——

Mr. FINE. You could not run out of the money.

Mr. ROGERS. But, is it logical to assume that someone is going to deliver services having the compensation pro rated?

Mr. FINE. Yes, sir.

Mr. ROGERS. Your members would not want to do that. In other words, I am trying to look at a practical approach. I notice that you say——

Mr. FINE. Let me answer that question.

Mr. ROGERS. Certainly.

Mr. FINE. We believe that physicians who elect a fee for service system, as would be their option, are entitled to reasonable fees. The negotiating process which Mr. Glasser has described would be operating. There would be reasonable fees paid. The system ought to work without pro rating.

Mr. ROGERS. How? What concerns me is that process of how that is first determined.

Now, once that determination is made and there is supposed to be money for a reasonable payment—suppose the man has more patients, suppose that group has more people come in, suppose there were extraordinary costs; in other words, more people had more expensive health problems than they had anticipated or than they had had last year, how is this accounted for? This is one of my concerns.

Mr. FINE. The need within a given year for the whole State of Indiana is really predictable. It is not based on the individual physician, Mr. Chairman, it is based upon the entire group of physicians and the entire patient load within that State. Provision is made for contingencies, such as a large railroad accident.

Mr. ROGERS. I was not thinking of that. I understand that. I am thinking about where you might need more surgery, for example.

Mr. FINE. Within the entire State. You would be able to predict for 12 months the surgery. We think realistically you can make predictions about that. If the increase was so substantial there would have to be a prorating of fees for that particular class of surgery.

Mr. ROGERS. In effect we are putting them in a group for payment purposes?

Mr. FINE. For payment, yes.

Mr. ROGERS. Although they may say they are practicing individually, they are in effect——

Mr. FINE. They are practicing individually. The IPA in the HMO legislation is the same system.

Mr. ROGERS. I understand. But in effect we are putting them in HMO payment arrangement, although we are letting them practice individually. It is like a foundation arrangement?

Mr. FINE. Yes, sir, a foundation, that is right.

Mr. ROGERS. I understand.

Dr. Carter.

Mr. CARTER. Thank you.

I believe that you would finance this program by a 50 percent payroll tax and 50 percent from the general fund, is that correct?

Mr. FINE. Yes, sir.

Mr. CARTER. What about our small employers who are marginal, how would we handle that?

Mr. FINE. I did not hear you.

Mr. CARTER. What about small employers who are marginal in profits. At this time we have many, as you know.

Mr. FINE. Yes.

Mr. CARTER. I have forgotten how many bankruptcies we had last year, I do not recall, but I looked over a list just recently. How would we handle employers of a marginal company?

Mr. FINE. In the same way as the AMA bill provides that every employer, even of one employee, would have to offer that employee the coverage. This bill provides that every employer as a cost of doing business would have to provide for the coverage, pay 3½ percent of payroll and the employee pays 1 percent.

Mr. CARTER. The employee paying——

Mr. FINE. One percent up to $21,000.

Mr. CARTER. One percent up to $21,000?

Mr. Fine. Yes, sir, that is the employee. The employer will pay 3½ percent of payroll. You recognize the offset that immediately occurs to most employers, because most employers, including even small employers, are providing some form of health insurance.

Mr. Carter. Yes. Well, that is quite true. Of course, I know that your group has perhaps one of the best insurances in the country. It costs approximately $1,100 a year, is that true?

Mr. Glasser. The last time I talked to you that was the correct number. I regret to say at the moment it is costing for every active employee in the automobile industry, at least with one of the major employers, $1,700 a year, for the same thing I talked about $1,100 here last year.

Mr. Carter. That is exactly right. And what percentage of that is paid by the employer in this case?

Mr. Glasser. Entirely paid by the employer.

Mr. Carter. Many of our larger companies, of course, can afford this, but when it gets down to the smaller ones it means they go out of business, in some cases.

Mr. Glasser. The 3½-percent social security tax would not approach these numbers in terms of employer payments, you see. Assume an average of $10,000 as a wage, which is not a bad figure to use, you are talking about $350 as the employer payment, if my arithmetic is right.

Mr. Carter. $350?

Mr. Glasser. $350, not $1,700.

Mr. Carter. And you think that it could be managed with a total payment then of $700 per individual, is that correct?

Mr. Glasser. I am sorry, you cannot play the arithmetic that way. The 3½ percent plus 1 percent equals 4½ percent and that covers half the cost of the system. The other half comes from general revenues.

Mr. Carter. Yes, sir; we would hope that it would. At the present time how much is taken from the social security? What does the employer pay?

Mr. Glasser. 5.85 and 0.9.

Mr. Carter. You would add to that how much, 3.5?

Mr. Glasser. Well, no, we would add, it is 5.85.

Mr. Carter. Yes.

Mr. Glasser. And to that would be added 3.5 and from that would be deducted 0.9. Point nine is the medicare tax which would be eliminated and that medicare tax moves up in 1978 to 1 percent even.

Mr. Carter. The medicare tax would be taken away from that?

Mr. Glasser. That is correct.

Mr. Carter. That would leave—that is 0.9 percent?

Mr. Glasser. Is the present medicare tax on employee and employer?

Mr. Carter. And that would leave the contribution 8.65 from the employer?

Mr. Fine. 8.45, is it not?

Mr. Carter. That is correct. All right.

Mr. Woodcock. However, Dr. Carter, the 3.5 would be on the gross payroll whereas under the social security law the 5.85 tops out for the employer as well as the employee.

Mr. Carter. The 3.5 would be on the gross payroll?

Mr. Woodcock. Yes, sir.

Mr. Carter. And 5.85 is on the net payroll?

Mr. Woodcock. The current ceiling is $21,500; 3.5 on health security would be on total payroll.

Mr. Carter. We view in the future that that base might be increased, is that correct, might of necessity be increased for social security?

Mr. Woodcock. We certainly believe so, yes, sir.

Mr. Carter. Do you think the economy of our smaller employers could stand this?

Mr. Woodcock. Very frankly, as I see the situation of the small marginal employer that you posed, he is now going to have to pay 3.5 percent on the gross payroll which obviously could be a burden to him, but his employees would be getting an economic benefit of inestimable importance, namely, full health protection. So whether or not he had a union or did not have a union, and many of them do not, the basic could be adjusted to take those incremental costs into being for the protection of the entire process in response for including his people in and their families in total health protection.

Mr. Carter. Yes, sir. Now, I believe you stated that 50 percent of the cost of that would be paid by the employer. That is what you estimated, is that correct?

Mr. Woodcock. Yes.

Mr. Carter. Of all the costs of the health insurance?

Mr. Glasser. Let us try that again. The social security taxes would produce 50 percent of the revenue.

Mr. Carter. Yes.

Mr. Glasser. General revenues would produce the other 50 percent.

Mr. Carter. All right, sir. Well, actually, in this case you are just putting an added tax as a social security tax. You are calling it a social security tax.

Mr. Glasser. Health security tax.

Mr. Carter. A health security tax. But you have a different base for applying it?

Mr. Glasser. That is correct. In the sense that there would be, as Mr. Woodcock has indicated, no ceiling on payrolls on the employer.

Mr. Carter. What is the average wage, monthly or yearly wage, of a UAW employee, please, sir?

Mr. Woodcock. Well, unless you take the biggest companies, our wages are all over the lot because we have got literally thousands.

Mr. Carter. Let us take one of your smaller companies like AMC.

Mr. Woodcock. Well, AMC is small only in relation to General Motors, Ford, and Chrysler and it is not small in the normal sense of the word.

Mr. Carter. Let us take it, then.

Mr. Woodcock. Their average wage now must be about 6.35, 6.40.

Mr. Carter. A year?

Mr. Woodcock. That is the hourly rate, which assuming they work full-time, would translate to a little over $13,000.

Mr. Carter. A year? That is a pretty good wage put out by a rather good company.

How much did they lose this year, AMC? What were their losses?

Mr. Woodcock. I do not have those numbers readily available.

Mr. Carter. I do not think they made money except for one quarter of this year. Perhaps the last quarter they might have broken even.

Now, for Chrysler, how would it affect Chrysler if they paid an additional 3.5 percent from their payroll?

Mr. Woodcock. All of the four automobile——

Mr. Carter. Chrysler has lost——

Mr. Woodcock. In health security——

Mr. Carter. Is the biggest loser with some part of the better cars.

Mr. Woodcock. If health security were by some magic in place right now Chrysler would save 22 cents per man-hour on its labor costs.

Mr. Carter. It would save 22 cents?

Mr. Woodcock. Because it is paying more to the private sector than this would require them to pay.

Mr. Carter. Can you show me that?

Mr. Woodcock. Yes, sir, we will send it to you.

[The following information was received for the record:]

Payments to Providers

Hospitals, skilled nursing homes and other types of institutional providers would operate on an approved budget basis rather than being able to charge whatever they decided.

Using the previous year's fiscal experience and taking into account standards of participation, range of desirable services and quality controls required by Health Security, the institutions would develop proposed budgets for the next fiscal year. They would be assisted by the regional and local offices of Health Security in preparation of their budget requests. The budgets would be reviewed and given final approval at the regional office level.

Money allocated for payment of individuals, such as physicians, dentists, podiatrists, etc., would be distributed to local areas within the region. This would be done on a per capita basis with adjustments for differences in the cost of goods and services. The budgeted per capita amount for each type of covered service would be divided between the categories of providers according to the number of individuals who elected to receive care from those providers.

For example: In a city of 100,000 people, 25,000 may be enrolled in health maintenance organizations. If the amount budgeted for physicians services in that area is $65 per capita, the Board would pay the HMOs $1,625,000—$65×25,000—for physicians services. Since the other 75,000 individuals elected to receive care from solo, free-for-service practitioners, the Board would create a fund of $4,875,000—$65×75,000—to pay all fee-for-service bills submitted by physicians in the community.

Estimated per capita hours savings under health security, based on experience with one major corporation

	1973
1. Reported hospital-surgical-medical-drug hourly cost	[1] 0.495
2. Estimated medicare tax (employer payment)	.054
3. Total	.549
4. Projected health security tax[2] at 4.5% (3.5% employer plus 1% employee)	.287
5. Cost of continuing certain benefits not fully covered by health security[3]	.040
6. Total 4 and 5	.327
7. Savings (6–3)	.222

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[1] Estimated.

[2] Earnings subject to proposed health security tax for 1973—$6.38 per hour.

[3] Primarily prescription drugs at about 8 percent of total premium.

Mr. Carter. I would like to see your figures that would back that statement up. I am sure you have them, no doubt.

Now, you speak of Canada, the Canadian plan. Is it quite similar to the Canadian plan?

Mr. FINE. Health security has some similarities and some differences. The similarities are in the area of requiring prospective budgeting by the hospitals as we have described. The differences would be in the extent of leverage within this program of health security to create changes in the system. There would be incentives in this system for prepaid group practice, HMO. There would be a Resources Development Fund to encourage their growth, and there would be funds for the purpose of the program to provide more places in health professions educational schools, et cetera. But the anchored budgeting is very similar to that in Canada.

Mr. CARTER. And you would envision two groups, as I understand it, one for HMO's, is that correct, and one for groups? Physicians would be in groups for the purpose of payments, is that correct?

Mr. FINE. Let us try it once more. The physicians could elect to be paid in a variety of ways. They could elect to be paid, if they happen to be in groups, on a capitation basis. If they happen to be primary physicians they could elect to be paid on a capitation basis as well. They could elect to be paid through a medical society-sponsored foundation through an IPA, through a Blue Shield plan. They can elect to be paid in a variety of ways. And in that sense, they are in groups for the election of their payment system. In the sense of practicing together, this does not put them into two groups. It is a different definition of the word "group."

Mr. CARTER. Their payments would be the same if they were in an HMO or if they were in another group?

Mr. FINE. Yes; it would be.

Mr. CARTER. It would be the same?

Mr. FINE. For the entire group.

Mr. CARTER. Whether it were by capitation——

Mr. FINE Yes.

Mr. CARTER. Or fee for service?

Mr. FINE. Yes; it would be different than medicare. Medicare said to the individual solo practice, fee for service physician, said, we will pay you 80 percent of your usual customary reasonable fee. It said to the prepaid group practice, all we are going to pay you is 80 percent of your cost.

Now we have made some progress in this area. We think they ought to be equal payments and the competition ought to be encouraged. We ought to develop new forms of HMO's, more experimentation in this area, and they ought to have an opportunity to be paid as well as the solo practicing fee for service physician.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. May I ask this now? You have the Budget Committee of the Board come together with the groups and the regional people, to set an overall budget based on last year's expenditure plus an inflationary factor. Do you always have the costs of living inflationary factor as the control, or will you limit that?

Mr. FINE. I think you have to look at the physician's cost of doing business also in your equation, and if that happens to have some unique features that cause that cost of living to escalate at a different rate you have to take that into account. But the answer to your question is yes, you always have that as your factor.

Mr. ROGERS. I believe you projected a limit on hospital cost increases of 8 percent per annum, and doctors and dentists, of 5 percent per annum.

Mr. FINE. Yes.

Mr. ROGERS. I understood from your testimony that you set a cap on this inflation factor.

Mr. FINE. Yes, sir.

Mr. ROGERS. I hope those predictions are good. Our inflation pattern has not been predictable, so if we based our future on the past, as you wanted to do your budget, that would hardly be adequate would it?

Mr. FINE. We accept we are not basing the future on the past.

Mr. ROGERS. I thought you based your budget on what you expended last year.

Mr. FINE. That is correct.

Mr. ROGERS. If the inflation in medical care costs last year was 13 percent, or 15 percent——

Mr. FINE. Then we have to accept that.

Mr. ROGERS. You are not doing that.

Mr. FINE. We are not accepting it once the program begins. You cannot do anything about that under this program until this program begins.

Mr. ROGERS. Well, should we also belie the past by unrealistic projections into the future until the program——

Mr. FINE. No; we are proposing to start where we are.

Mr. ROGERS. I understand, but are you then projecting an 8-percent cost increase for hospitals and a 5-percent cost increase for physicians?

Mr. FINE. For future years.

Mr. ROGERS. I understand. I am not sure that is a legitimate projection. That is all I am saying.

Mr. FINE. I understand.

Mr. ROGERS. And do you agree with that?

Mr. FINE. We think the actuary who did an analysis came up with those figures.

Mr. ROGERS. I understand that. But I am saying, do you really think that is a proper projection, an 8 percent and a 5 percent inflationary factor?

Mr. FINE. I have a lot of confidence in the actuary.

Mr. GLASSER. Could I indicate this? The health care costs are moving at a rate of 50 percent higher than the increase in the cost of living, as you know, 40 to 50 percent. Assuming the actuaries are incorrect, the inflation rate in the base year is not 8 percent, it is 11 percent.

Mr. ROGERS. Or 13.

Mr. GLASSER. We will take even numbers so I can add. Let us say it is 14 percent, not 8. What would happen without this kind of a program is we have every reason to believe that health care costs would go up 21 percent under the health security program, they would be capped at 14 percent. That is the difference.

Mr. ROGERS. That would be the difference for 1 year?

Mr. GLASSER. That is right.

Mr. Rogers. And because you would then base it on the next year's experience, it might be 21 the next year.

Mr. Glasser. If it were that would have to be the ceiling. We do not expect health security can control the economy, obviously.

Mr. Rogers. I understand. What I am saying is that I am not sure of the legitimacy of the projections of 8 and 5 percent respectively at this time. I presume you would agree with that?

Mr. Glasser. The number is certainly not one baked in cement but the relationship is. In other words, the increase in health care costs in any given year would not run 40- to 50-percent higher than the actual increase in cost of living. They would not be permitted to go above the actual increase, whatever that number is.

Mr. Rogers. Well, if the inflation factor is 21 percent, then the increase is 21 percent.

Mr. Glasser. Yes; but in the absence of a health security program, or if you adopt CHIP or the health insurance industry program, if it is 21 percent based on our present experience, you would have it in the neighborhood of 35 percent.

Mr. Rogers. I am not saying what might happen, I am saying your plan builds in, as I understand it, the cost-of-living increase.

Mr. Glasser. That is correct.

Mr. Rogers. And in health, if it turns out to be 21 percent, it will be projected as a 21-percent increase the next year?

Mr. Glasser. In the economy, 21 percent, not in health.

Mr. Rogers. You would only build in the increase in the economy?

Mr. Glasser. That is right.

Mr. Rogers. Let us suppose the actual cost increases have been running 21 percent in health and you only want to give them 8 percent.

Mr. Glasser. That is not built into the program. What is built into the program, you start with the base year. We cannot control——

Mr. Rogers. We are doing that.

Mr. Glasser. Whatever the base year is.

Mr. Rogers. Then you take only the cost-of-living increase but you do not relate that to what happens in the health field?

Mr. Glasser. That question has come up now, sir, several times by several Members of the Congress.

Let me say this. If one looks at the utilization of services over the years in America's health care system, they do not change significantly. They may change from one group to another, from one location to another, but the insurance principle of spreading the risk over 210 million people works. So we have no reason to assume, based on experience, that in fact there will be major differences in the utilization of services except that we hope that the availability of comprehensive and preventive services will in fact reduce in-hospital utilization, which is really where the money is, and free a great deal more moneys for outer-hospital and preventive services. But the notion that the inclusion of coverage would significantly increase, let us say surgery or other kinds of services, has not been borne out by other countries and is not likely to occur in this country—it just does not happen.

Mr. Rogers. What I am concerned about is the fact we are projecting some figures that may not hold true. I think the committee should be aware of all of this, and we are going into this in every plan in some detail.

Mr. WOODCOCK. There is not a question the 8 and 5 percent are assumptions.

Mr. ROGERS. Thank you. That is what I presume.

Mr. WOODCOCK. I do not know whether they are Weinberger assumptions which we took over.

Mr. ROGERS. Those are not very good assumptions, Mr. Woodcock.

Mr. WOODCOCK. Or whether we put these in.

Mr. ROGERS. I think that straightens out that matter, that they are assumptions and may or may not prove to be so.

Let me ask you this: As I understand it, you will have a 3.5-percent tax on employers' payrolls, 1-percent tax on employees' wages, and on unearned income up to $20,000 a year?

Mr. WOODCOCK. $21,000.

Mr. FINE. That is a dynamic 150 percent of the OAS base.

Mr. ROGERS. All right. And, as I understand it, through negotiations the employer could agree to pay the employee's percentage?

Mr. FINE. Yes.

Mr. ROGERS. Would that be correct?

Mr. FINE. Yes, sir.

Mr. WOODCOCK. As a matter of fact, our contracts provide currently that if there is a change the employer will absorb the employee cost.

Mr. ROGERS. Then, the tax on income of the self-employed is up to $21,000 now, instead of $20,000.

Mr. FINE. Yes.

Mr. ROGERS. Then contributions, of course, from the Federal general revenue are equal to the total amount collected through health security taxes. As I recall, you also eliminate any income tax deductions people might take for health care, if it is under a covered service?

Mr. FINE. Yes.

Mr. ROGERS. Would that be correct?

Mr. FINE. Yes.

Mr. ROGERS. Does that apply to the employer, too?

Mr. FINE. The individual income tax deductions for medical costs?

Mr. ROGERS. In other words, would he only be able to take a deduction on his corporate income tax for the taxes paid for this health program; or could the employer take deductions for benefits over and above what is covered under the program?

Mr. FINE. We are silent on that. He could. We make no change in that provision.

Mr. ROGERS. All right. You would anticipate that he would then take tax deductions for any amounts paid for benefits not covered under the program?

Mr. FINE. He may, for example, agree to provide adult dental care, which is not covered under this, and he can take a deduction on that.

Mr. ROGERS. I see.

Now, what about retired people, do they pay after they are 60? What do they pay?

Mr. FINE. The exemption of age 60 is the first $5,000 plus any social security benefits. They pay 1 percent above that on earned or unearned income.

Mr. ROGERS. Earned or unearned?

Mr. Fine. Yes, sir.

Mr. Rogers. And, then, of course, the general Treasury comes in.

As I understand it, if at the end of the year you find the taxes did not provide sufficient amounts, the Secretary of the Treasury may come to the Congress in the next year and ask for an increase in taxes?

Mr. Fine. That is provided, yes.

Mr. Rogers. Pardon?

Mr. Fine. Yes, sir.

Mr. Rogers. Do you provide for increased taxes as your inflationary factor is applied each year? Is that split between the taxes and the general Treasury?

Mr. Fine. Yes.

Mr. Rogers. So would you expect to have an increase in taxes directly related to the cost of living each year? If it is 8 percent, would you have an increase in taxes of 8 percent?

Mr. Fine. We expect the economy would continue to rise and increase in GNP would offset these additional costs. It would be taxes on a larger base.

Mr. Rogers. I beg your pardon?

Mr. Fine. We expect the gross national product to continue to rise, too, as these costs rise, and this would compensate for the additional amounts needed to provide for the benefits under this program.

Mr. Rogers. Well, I am not sure——

Mr. Fine. You were talking originally about recession. In a recession you have to assume also a less than a steady rise in health costs. They also under this program would not be permitted to rise. So the costs would not escalate in the terms that you are describing. However, if you have a period of continued prosperity, the GNP increased, the tax base will broaden and there would be a greater tax fund under the existing program to pay for the increased costs of the benefit.

Mr. Rogers. Why would it be greater when you have already got your tax base pretty much set and the general Treasury matches your base?

Mr. Fine. Your employer's payroll would rise as well.

Mr. Rogers. If inflation is controlled, I can see this happening. But if inflation is not controlled, you still have the inflationary factor built in, no matter what it is, and so you would still have an increase in your costs and in your tax base. You are assuming in a millenium there would be no inflation that could not be paid for with the higher tax base resulting from an increased gross national product; is that right?

Mr. Fine. The tax base. We are now talking about the payroll tax.

Mr. Rogers. I am talking about the payroll tax, as well, because you say that you match from the general Treasury what comes in from the payroll. So that is the overriding factor.

I do not care if you have a $600 billion gross national product, if you have a 21-percent inflation, from that tax base you have still got to get some more taxes to pay for the extra costs. Would you not agree?

Mr. Woodcock. I would say, sir, unless we are dedicated to permanent recession, and I am beginning to wonder. The inflation factor would in whatever form feed itself into the wage system.

Mr. Rogers. Certainly. That is the point. I do not think——

Mr. Woodcock. So the taxes would rise based on the inflation without any congressional action.

Mr. **Rogers**. I am sure that may be so. But you build in an increase related to inflation, as I understand it, in the program. You say we will set a budget related to what was spent the last year plus the inflationary factor. So there would be an increase in taxes, I presume?

Mr. **Glasser**. There would be an increase in dollars but not necessarily and unlikely in percentages.

Mr. **Rogers**. I presume you would not change the percentage at all?

Mr. **Glasser**. That is right.

Mr. **Rogers**. I would hope not.

Mr. **Glasser**. That is right.

Mr. **Rogers**. You have set the tax rate at 3.5 percent. If you have a growing gross national product but it does not keep up with your inflation factor, in other words, if your gross national product has not grown to the extent your costs have jumped, in the health area, then what happens?

Mr. **Glasser**. Let us take the $10,000-a-year worker. He is in a period of inflation. The inflation rate is 20 percent. I do not like that illustration. Ten percent. The inflation rate is 10 percent. This will be reflected, of course, in wages and in income. That same 1 percent on the employee and 3½ percent on the employer will, therefore, produce 10 percent more revenue. Since you have a cap on the health system of 10 percent, because that is what the COL is, therefore, the taxes will produce more dollars but not a larger percentage. So you would not have to go back to the Congress in most situations to say to the Congress, 3.5 and 1 are not enough, we need 3.6 and 1.1.

Mr. **Rogers**. Has this proved true in the Social Security System in medicaid?

Mr. **Glasser**. In medicaid?

Mr. **Rogers**. In both medicaid and medicare. Of course, medicaid is funded from the General Treasury.

Mr. **Glasser**. Medicaid is a different system. Under medicaid the problem there is there are no ceilings. That is our problem. It is an open end. So that the answer to you is categorically, no, it has not been proven so in Medicare because there are no ceilings.

Mr. **Rogers**. But if you negotiate each year, what keeps the ceiling?

Mr. **Glasser**. The keeping the formula written into the Health Security Act. That is the way we write most of our contracts in the Federal Government except in health care.

Mr. **Rogers**. Is this the way you generally negotiate for your union? Do you hold to a cost-of-living increase from a base year? is that generally done?

Mr. **Fine**. In health care.

Mr. **Rogers**. In your union contracts?

Mr. **Woodcock**. Well, we do not approach the union contract on a budgeting basis. Our basic wage contracts say annual increase plus escalator, which is after the event, including after the event in point of time.

Mr. **Rogers**. Yes, but then it does not just include the inflationary factor, the cost of living? Does it only include——

Mr. **Woodcock**. The wage system does include the inflation.

Mr. **Rogers**. Does it include anything else? That is what I was saying.

Mr. **Woodcock**. Not the wage system.

Mr. Rogers. So none of your contracts call for anything more than simply increasing in relation to increases in the cost of living?

Mr. Woodcock. And the annual increase which is tied to the national productivity rather than the productivity of that industry or enterprise, currently 3 percent.

Mr. Rogers. Should that be included in a health packet?

Mr. Woodcock. I would think not, given the current situation that we have.

Mr. Rogers. Why not? If it should be in other contracts why should it not be here?

Mr. Glasser. May I say it should not be, sir, because the wage situation is not a thoroughly good analogy to the health care situation.

Mr. Rogers. I thought we were in effect getting a wage situation here now, are we not, by putting a cap on total budget and prorating funds among providers if there is not enough money?

Mr. Glasser. We are not getting into a wage situation at all. We are trying to cap a complex health system, because the cost of living in wages together with the 3 percent takes into account two things; a national productivity and, therefore, some increase in standard of living; whereas we are in this instance not talking about a situation where we need to be concerned about the standard of living of the providers. They are now the highest 1 percent of professional incomes in the United States.

Mr. Rogers. What about exclusions in your plan. Dental care is covered beginning up to age 15. Have there been any changes there?

Mr. Fine. No, sir, that remains pretty much as it was. At the outset, children up to age 15 would be covered. There would be a projection of 2 years for every year. After 7 years the board would make a determination of universal availability.

Mr. Rogers. Are the elderly covered for dental services in this bill?

Mr. Fine. After 7 years they would be.

Mr. Rogers. Not now?

Mr. Fine. No, no one over age 15 would initially be covered.

I might say that the reason for that was in the preparation of that legislation we had a number of technical subcommittees. One of them was in the dental area. We had practicing dentists, academicians and others who cautioned us in view of the fact only 40 percent of the American people today ever see a dentist, it would be unwise at the outset to have a universal benefit and to move slowly.

Mr. Rogers. The elderly are not covered then for dental care in this bill?

Mr. Fine. Not——

Mr. Rogers. Or any adult?

Mr. Fine. Not initially.

Mr. Rogers. Not for 7 years?

Mr. Carter. Not then above 25 years?

Mr. Fine. Beg pardon?

Mr. Carter. Not even then above 25 years?

Mr. Fine. After 7 years the Board would make a determination of universality.

Mr. Rogers. Are they required to bring them in at the end of 7 years or simply to present a plan to bring them in?

Mr. **Fine**. It is to look at the situation at that time. The 7 years is reviewed as a resources-development period.

Mr. **Rogers**. All right, In regard to medical appliances, you have a 2-percent cap on that?

Mr. **Fine**. Of the trust fund.

Mr. **Rogers**. What does this include? Would that include eyeglasses, hearing aids?

Mr. **Fine**. Yes, sir.

Mr. **Rogers**. Would it include false teeth? I presume it would, although perhaps that would go in the dental care.

Mr. **Glasser**. That is on the dental side.

Mr. **Rogers**. Now, what happens if the expenditure is more than 2 percent?

Mr. **Fine**. Again, we are talking about a finite sum of dollars for specified benefits. It is our judgment based upon the data that we have looked at that that should do it. If it does not we would have to examine it again and prorate some of this.

Mr. **Rogers**. I wonder if it really will, because each year, as you know, we are having a longevity increase, more and more senior citizens. Is there a way to take that into account when the figure is based on a figure from a base year, when we know there may be more people that may have these needs?

Mr. **Fine**. Of course, the bill provides that every year we have to look at it again.

Mr. **Rogers**. You base your budget on last year, do you not?

Mr. **Fine**. Yes, sir.

Mr. **Rogers**. Plus inflationary factors, not on changed health needs?

Mr. **Fine**. They may change year by year but more likely they change over a period of years.

Mr. **Rogers**. I think we need to get at this, too. I am not sure we should always make our judgment on what happened last year, based simply on cost, but maybe we also ought to look at what the needs are. Would you agree?

Mr. **Fine**. Yes, sir.

Mr. **Carter**. About your plan's coverage of psychiatric care, would you like to elucidate on that a little bit?

Mr. **Glasser**. The coverage under the health security bill?

Mr. **Carter**. Yes.

Mr. **Glasser**. The health security bill provides for those patients who elect to receive their services in organized programs and HMO's, no ceiling on psychiatry out of hospital or in-hospital except as determined by the HMO.

For those who elect to receive their services under the solo practice system it provides essentially for up to 20 out-patient psychiatric visits per year and up to 45 days of in-patient psychiatric care per year.

Mr. **Carter**. I believe my résumé of your bill should be updated then. According to it, I see 60 days there as your limit.

Mr. **Glasser**. It is 45, sir.

Mr. **Rogers**. I think in these notes it says 60 days for care of a psychiatric patient in a mental health day care service; that is what the 60-day limit refers to.

Mr. **Carter**. What happens to the patient then after the 45 days?

Mr. **Glasser**. I can tell you from our experience over 11 years now with the UAW benefit, and with other programs, that in practically all instances if a patient is not amenable to change on an in-patient basis in the first 45 days he is a chronic long-term patient.

Mr. Carter. That is right.

Mr. Glasser. And there is still in place the series of State mental health programs and institutions which are designed to take care of the long-term patient. This bill does not provide for long-term care of the mentally ill who are not amenable to treatment which produces change.

Mr. Carter. You would confine this patient to a snakepit after 60 days; is that correct?

Mr. Glasser. I would not like to say that the State mental hospitals are snakepits. I would agree some are. Our hopes are and experience in the UAW indicates a good deal of hope if you can get at patients early enough and get them under good care early enough those snakepits will gradually disappear.

Mr. Carter. I would hope they would disappear from the face of the Earth.

Mr. Glasser. I join you in that.

Mr. Rogers. Now, just a question or two. You have been very kind to be so patient with us.

I think probably what we might ask you to do later, Mr. Woodcock, or perhaps we could ask your colleagues—I do not think it would be required for you to be here—would be to go over some details with the committee that I think we need. There are many areas where we are just scratching the surface right now, and I think if we could work out an agreeable time that would be convenient for you it would be helpful to the committee if we could go over some of our questions in more detail. We plan to do this with each plan. If that would be agreeable, we would like to make some arrangement later on to do that, perhaps after the first of the year.

Mr. Woodcock. We would be happy to do it. It is quite obvious you have done some hard analysis and we are very grateful.

Mr. Rogers. Not enough. But there are questions I think we need to address. For example, malpractice; you do not allow suits if it is a service which is covered, is that correct?

Mr. Fine. Yes.

Mr. Rogers. They would be permitted otherwise?

Mr. Fine. Yes, sir.

Dr. Rogers. Would malpractice insurance be a part of the cost of doing business as far as reimbursement within the budget is concerned?

Mr. Fine. We recognize, Mr. Chairman, the tremendous malpractice insurance problem. At the time of the drafting of this legislation, of course, the Secretary's Commission was at work and the legislation referred to, H.R. 21, refers to that work and the fact that we would have to take a look at the recommendations of that Commission.

The answer to your question does the payment for the physician's service include recognition of his increasing malpractice premium? Obviously, this is a cost of doing business that is increasing tremendously and that is a factor we have to take account of, but we really are looking toward the kind of legislation, whether State or Federal level, in this field that would stop this irrational system that we have in the malpractice area.

Mr. CARTER. Mr. Chairman, I noticed that any physician who has passed a State examination would be covered under your program, is that correct, at the present time? Future physicians would have a different type of examination?

Mr. FINE. Not exactly. The legislation provides that if you are licensed in the State and you also pass national boards, that you would be under this program eligible to provide services in other States as well.

Mr. CARTER. At the start of the program independent practitioners would be eligible to participate if they were licensed in at least one State and met the program's requirement for continuing education, is that correct?

Mr. FINE. That is correct.

Mr. CARTER. All right, that is after the passage of this legislation. Then after such time, I think that is at odds with what you said there.

Mr. ROGERS. We understood, if the gentleman will permit——

Mr. CARTER. Yes.

Mr. ROGERS. Those who are currently practicing would be permitted to continue, but after the passage of the legislation there would have to be in effect, a national——

Mr. CARTER. That is right.

Mr. ROGERS [continuing]. Licensure—along with the State; is that not correct?

Mr. FINE. In the sense that I have described, those who have passed national boards would be eligible to provide services under this program in other States as well.

Mr. ROGERS. That have passed their national boards?

Mr. FINE. Yes, sir.

Mr. ROGERS. Who sets the terms of that? Would it be the Board?

Mr. FINE. The Board, yes.

Mr. ROGERS. Or would it be the individual colleges as currently done now?

Mr. FINE. They are the groups that provide the national board examinations.

Mr. ROGERS. I did not know whether the Board as you set up——

Mr. FINE. No, no.

Mr. ROGERS. They would not have the final say?

Mr. FINE. No.

Mr. CARTER. Let me understand you, if you please, Mr. Chairman.

At the start of the program independent practitioners would be eligible to practice if they were licensed in at least one State and met the program's requirements for continuing education. Is that true or false?

Mr. FINE. That is true.

Mr. CARTER. They would be accepted into your group then?

Mr. FINE. They would be eligible to provide services.

Mr. CARTER. All right. After enactment of this law, if it should come about, would these same physicians be eligible to practice in another State?

Mr. FINE. Well, if they were licensed in that other State or if they passed the national boards that would give them licensure in effect under this program.

Mr. CARTER. Yes, all right, thank you very much.

Mr. ROGERS. Now let me ask this. You phase out certain current programs, as soon as we move into this, such as Medicaid. In effect, you phase that program out, although you would allow some supplemental support if a State decided to do it, as I understand it?

Mr. FINE. Yes, sir.

Mr. ROGERS. Now, would the States also contribute to that residual part of Medicaid?

Mr. FINE. Yes; the State would have to.

Mr. ROGERS. You still would envision part of the program would have a State contribution?

Mr. FINE. Yes. Incidentally, the States and the local governments under this program, however, would be relieved of approximately $5½ billion of existing personal health care expenditures.

Mr. ROGERS. Yes.

I understand you do not do anything with the Veterans' Administration, disability, workmen's compensation, Department of Defense, and HEW programs serving the merchant marine and Alaskan Natives, but study would be done on what should happen there? What do you envision?

Mr. FINE. Well, No. 1, all of the population groups that you have just described are entitled just as everyone else who lives in the country, to the benefits under health security. We are not proposing that the health security program take over the Indian Health Service or take over the veterans hospital system. In other words, they would have dual entitlement under those systems. In practicality, quite obviously, there would be an impact. More likely the veterans hospital system would become a long-term care institution and there would be a similar impact in other programs.

I do not know that the Indian Health Service would change materially except the places where they are close to urban areas.

Mr. ROGERS. Finally, let me just ask this; we will get into some details later on. In the budget process, which is what concerns me, as I understand it, the individual goes through a group for negotiating purposes; the provider groups and the hospitals negotiate. Does each individual hospital negotiate, is it done through a State association, with some sort of group negotiation?

Mr. FINE. The hospitals and other institutions prepare prospective budgets. These are prepared not only in terms of the hospital's own internal and external services but also in some relationship to neighboring hospitals because we are trying to weed out some of the waste and duplication. It is the same hospital budget system or very much the same as is now in Canada. That process at the local level results in an approved budget at the regional level but it begins in the local level. This is where the additional personnel would be largely needed for that type of budgeting system, that is, the hospitals are not today engaged in. So it is a different system in terms of the hospital or institutional budgeting system than it is with the physicians to that extent.

Mr. Rogers. So that each hospital would make up its projected budget and turn it into the regional board, or would it go through the State or——

Mr. Fine. It would go through the State. The legislation provides. that the State must be consulted in this process and it is really going through your new planning legislation.

Mr. Rogers. Would you use the planning mechanisms——

Mr. Fine. Yes.

Mr. Rogers [continuing]. Health service agency?

Mr. Fine. Yes, sir; the bill was written at the time of the President's signature to assure that.

Mr. Rogers. All right, so then the individual groups such as the group practice associations we have now, would be handled as you handle individuals operating through a representative group, or do you let each of those groups make up their own budget; an HMO, a large group practice—what would happen there?

Mr. Fine. Are we talking about——

Mr. Rogers. For budget purposes?

Mr. Fine. For their hospital provided services?

Mr. Rogers. For their payment.

Mr. Fine. Their total for the patients who join that group?

Mr. Rogers. Yes.

Mr. Fine. The groups that agree to receive services for a year under that capitation system would be paid the total capitation amount for each covered service that it provides, physician service and hospital services.

Mr. Rogers. I see. Now, do you have the same capitation amount for every group? Would it be identical?

Mr. Fine. In effect it is the same capitation amount for every individual. So that if the individual is in a system in which services are being provided to him or her, and their family, that system would receive the full capitation amount. If that family or that individual was receiving services from the solo practice system, the same amount would be allocated to that system.

Mr. Rogers. How is the determination made if there is a difference, for instance, between all of the individual practitioners who come together and negotiate with the regional people, and the group people who negotiate separately? Then you have your hospital people negotiating as a separate unit; who makes the final judgment on allocation of funds; how is that resolved?

Mr. Fine. The physicians initially elect their method of payment, each individual. Those who elect the capitation payment system and who find that x number of patients are seeking services through their system, they are paid the total capitation amount for the services that they are going to provide in this 12-month period. The fee-for-service practitioners, most of whom are practicing in their own offices and not in groups, are going to be paid under a system developed as in a process of negotiation that largely involves the foundation or the IPA, the negotiating instrumentality for that group of physicians. The negotiations will concern, in effect, relative values because the physicians themselves will have to determine within the finite sum of dollars available, the relative value of an appendectomy versus another procedure and also the relative value of being boarded would have to be determined within that group, but they can determine that on the basis of the group's desires and how it wants to allocate the capitation amounts that have been given to that fee-for-service system in the same amount as the other capitation system.

Mr. ROGERS. I do not think you have gotten the gist of my question. How do we determine that amount in the first place? In other words, the individual pratitioners come in and they may say, you know it is going to take $600 for every person I handled last year. Now the group says well, I think it is only going to take $550, but we are not going to do it for $550, if you are going to pay those guys $600. How do you resolve all of this? Who has the authority to resolve it?

Mr. FINE. The Board has the final authority. The Regional Board has the authority to resolve that type of difference.

Mr. ROGERS. Is there any appeal?

Mr. FINE. Yes.

Mr. ROGERS. Is it in the law?

Mr. FINE. Yes, sir.

Mr. ROGERS. Who do they appeal to, the National Board?

Mr. FINE. The National Board and to the courts if they find——

Mr. ROGERS. Do you think the National Board will have time to do all this negotiating and appeal taking? I expect there will be a great deal of it.

Mr. FINE. We think that the local providers will work it out by overwhelming majority.

Mr. ROGERS. You are an optimistic man.

Mr. CARTER. Mr. Chairman, on that I would like to ask what would you think the hours of practitioners would be in a group practice or in an HMO for a week?

Mr. FINE. What would the hours be?

Mr. CARTER. Yes.

Mr. FINE. The concern would be with the availability of the service according to the contractual hours. In other words, an HMO undertaking to provide comprehensive health services would have to assure the services availability 7 days a week and 24 hours a day in that situation. Obviously, this would require quite a number of physicians and by and large, in the HMO's I think that the physicians work no longer hours than in a solo practice and might work even fewer hours.

Mr. CARTER. Well, approximately how many hours? Would you envision a 40-hour week?

Mr. FINE. I think that is really up to the individual physician. Most of them work much longer than 40 hours now.

Mr. CARTER. They do. Now, I would like to ask you about that. Suppose they work, instead of 40 hours, 60 hours a week: Would you increase their pay? Would you give them overtime?

Mr. FINE. Their pay would automatically be increased or their income from the practice would automatically be increased.

Mr. CARTER. I thought you had a limit on that of so much—a finite amount for each group and it could not be exceeded.

Mr. FINE. Not for the individual.

Mr. CARTER. Sir?

Mr. FINE. Not for the individual.

Mr. CARTER. Not for the individual. And what about holidays? You know, sickness does not take a holiday. What would you do about that?

Mr. FINE. Well, I would assume——

Mr. CARTER. Would you give triple time forthat?

Mr. FINE. Well, I would assume within the system that the physicians might so decied that those——

Mr. CARTER. Would there be sufficient funds for that?

Mr. FINE. Might even decide to pay extra amounts for house calls.

Mr. CARTER. Thank you. Well, you know that is a very difficult thing. Those house calls are pretty hard—in my area, anyway.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you so much, Mr. Woodcock, Mr. Fine, and Mr. Glasser, you have been most patient with the committee. I think we have just skimmed the surface. There are many things we want to get into. I think you have given us much food for thought here on an approach that you have thought out well. It has been well presented. There are areas where I think we need more dialog and more work together, and we will look forward to pursuing that and any suggestions you have for the committee we will welcome.

We are grateful to you and thank you for being here and we will be in touch as we proceed because this is a very large program and it has such vital effect for the American people that we hope the legislation we fashion can be the right kind of legislation.

Thank you for your presence.

The subcommittee stands adjourned until 2:30 this afternoon when we will continue.

[Whereupon, at 1:30 p.m., the subcommittee was recessed, to reconvene at 2:30 p.m., this same day.]

AFTER RECESS

[The subcommittee reconvened at 2:30 p.m., Hon. Paul G. Rogers, presiding.]

Mr. ROGERS. The subcommittee will come to order, please. We are continuing our hearings on national health insurance. Without objection, the Chair wishes to place in the record, as though read, a statement submitted by Congressman Omar Burleson of Texas.

STATEMENT OF HON. OMAR BURLESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURLESON. Mr. Chairman, we are all acutely aware of the fact that this is a time both for careful appraisal of the health care needs of our people and responsible action to meet those needs. Our present health care system is fraught with serious problems of organization, inequitable delivery of services, maldistribution of manpower and facilities, quality of care, and rising costs. These problems will not disappear of their own accord; nor will our people quietly resign themselves to the perpetuation of a system which fails to respond effectively to their urgent needs for prompt and reliable access to high quality health care services of the types and amounts they require and at a cost they can afford to pay.

At the same time, all of us recognize the need to rigorously scrutinize the fiscal impact and implications of any new program that involves the expenditure of Federal funds. Given the Nation's current economic condition, we must use our resources wisely. And in my judgment that means designing a fiscally sound national program of health care financing and planning that will assure for all of us the most effective use of our health care resources. Mr. Chairman, I believe the National Health Care Act meets these requirements.

The bill I have introduced—H.R. 5990[1]—addresses the most complex problems facing us in the area of health care, including the problems of rising health care costs, manpower shortages, the lack of comprehensive ambulatory health care facilities, the absence of coordinated long-term health policy planning, and the existing inadequacies in health insurance protection. It does so by the most efficient, least expensive methods, while blending the expertise and strengths of the private sector with the unique capacities of Government.

The National Health Care Act contains several major provisions. First, it establishes cost and quality controls. All payments for health care would be tied to prevailing fees and to peer review of those professional services that fall outside of professionally established guidelines, thus assuring appropriateness of treatment, quality of care, and reasonableness of physician fees.

Rates charged by health care institutions would be subject to approval by a State Health Care Institutions Cost Commission appointed by the Governor. Each institution could be required to maintain a review committee to check on the appropriateness and quality of services to utilize a standard system of accounts and cost finding, and to use a "prospective approved charges" system involving prior review and approval of proposed charges by the State Commission in order to assure that charges are reasonably related to the cost of effectively providing necessary services.

Second, my bill sets minimum standards for health insurance policies and provides incentives for compliance with these standards. There is one standard for health care benefits for all Americans. Whether the health care plan is purchased by employers, by individuals or through a subsidized State plan for the poor, the minimum standards for all these plans are the same and would be phased in over the same period of time. There would be a broad range of benefits for everyone regardless of income or physical condition. Medical costs for the expenses of a catastrophic illness would be fully covered. Protection would be provided for the unemployed; and the poor would be enrolled in a State health care plan subsidized by State and Federal funds and managed by private insurance carriers. The risk for solvent individuals who are uninsurable solely for health reasons would be borne entirely by the health insurance industry.

I come now to those provisions of the National Health Care Act of most direct interest to this subcommittee—provisions relating to the supply and distribution of health care personnel and facilities, and long-range health policy planning. Title II of my bill contains provisions to increase the supply and improve the distribution of health care personnel by continuing grant and loan programs, and increasing the forgiveness of those loans over their present level, especially for service in areas designated as health scarcity areas including rural areas. The grants and loans are for physicians and allied health professionals, and include new training money for ambulatory care team training.

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[1] See p. 808 for full text of H.R. 5990.

Title III of my bill contains provisions to encourage the development of comprehensive ambulatory health care centers. This encouragement comes through the awarding of grants and loans for the construction and modernization of these urgently needed centers.

Finally, title IV of my bill addresses the problem of coordinating and strengthening health planning by requiring an annual Presidential health report and by establishing a Health Policy Board in the Executive Office of the President. The health report of the President would set forth the status and condition of the health care system of the Nation, assess current and foreseeable trends in the health care needs of the Nation, evaluate the adequacy of available health care resources, review the health programs and activities of Government entities, and suggest appropriate legislation.

The Health Policy Board would consist of three members knowledgeable in health care matters appointed by the President. The Board's functions would include: (a) assisting the President in the preparation of the health report; (b) reviewing Federal health programs and activities; (c) developing procedures for interagency coordination of Federal health programs; (d) continuously evaluate health programs and assist the President in the formulation of a national health policy designed to improve the organization, delivery, financing, and quality of health care.

Mr. Chairman, Next year is our Nation's 200th birthday. It is an appropriate time to reaffirm our faith in the free enterprise system which has made this country great. It is our traditional pluralistic approach to problems, the discipline and stimulus of competition, which has made this country to prosper and grow strong. The National Health Care Act retains, stimulates, and fosters a pluralistic, competitive health delivery and financing sytem for the benefit of all Americans. It represents an orderly approach to redressing the serious imbalances in our present health care system, particularly those persistent problems of personnel maldistribution, institutional bias in the delivery of services and uncoordinated health planning. I respectfully urge this subcommittee's close attention to those provisions which offer us an opportunity to more effectively utilize the health care talent and resources available to our Nation.

Mr. Rogers. Our next witness is Frederick E. Rathgeber, executive vice president, Prudential Insurance Co. of America, on behalf of the Health Insurance Association of America accompained by Mr. Daniel W. Pettengill, vice president, Aetna Life & Casualty, and Mr. Leslie P. Hemry, president of the Health Insurance Association of America.

We welcome you, gentlemen. We apologize for holding you up so long. Your statement or statements will be made a part of the record and you may proceed.

STATEMENT OF FREDERICK E. RATHGEBER, EXECUTIVE VICE PRESIDENT, PRUDENTIAL INSURANCE CO. OF AMERICA, ACCOMPANIED BY DANIEL W. PETTENGILL, VICE PRESIDENT, AETNA LIFE & CASUALTY, AND LESLIE P. HEMRY, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA IN BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN LIFE INSURANCE ASSOCIATION, AND THE LIFE INSURERS CONFERENCE

Mr. Rathgeber. Thank you, Mr. Chairman.

We appear today on behalf of the Health Insurance Association of America, the American Life Insurance Association, and the Life Insurers Conference. The 500 member companies of these associations provide more than 90 percent of the private health insurance underwritten by insurance companies in the United States.

As we indicated in prior congressional appearances, we strongly support the early enactment of a national health insurance program which would provide comprehensive insurance coverage to all Americans so that they can have access to quality medical care at a price they can afford. This objective can be most economically and efficiently achieved by modifying and improving the current health care delivery and insurance system, rather than by destroying it and building anew, with uncertain prospects of performance and efficiency. Specifically, we support the principles of any bill patterned along the lines of the National Health Care Act of 1975—H.R. 5990 [1]—introduced by Congressman Omar Burleson. I will limit my oral statement today to a summary of where our business stands on the national health insurance issues which have not as yet achieved a national consensus. I have with me a more complete statement of where we stand on the overall subject and I request your permission to file the complete statement for the record.

Mr. Rogers. Without objection, it is so ordered. [See p. 87.]

Mr. Rathgeber. Thank you.

At the outset, let us take a brief look at some of the events which have transpired in this country during the last 18 months. We have witnessed a major recession with accompanying heavy unemployment, coupled with a continuation of inflation which has been reflected in escalating health care costs, The Federal budget deficit is now running at a level of at least $60 billion a year and there is a real possibility that some local governments will default on their obligations. These developments have drawn the attention of legislators at all levels of government to certain realities of life. There is no pressing demand on the Congress for increased Federal encroachment into the private sector, larger Federal budgets, larger deficits, or increased taxes. It is becoming increasingly obvious that the public is becoming more concerned about the magnitude of these matters. They see the need to allocate our resources carefully among such essentials as defense, education, energy, the environment, food, housing, transportation, unemployment benefits, and welfare, as well as health care. This country, rich as it is, does not have unlimited resources.

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[1] See p. 808 for full text of H.R. 5990.

Against this background, how best and in what form should a national health insurance program be financed? Under whose auspices should it be administered? How should the continuing problem of the costs and quality of health care be dealt with under a national health insurance program? Other questions relate to the design and scope of the national health insurance benefits. We respectfully suggest that the Congress take a realistic approach toward resolving these questions.

There are two contrasting principles for the financing of a national health insurance system. The first would produce all funds from Federal sources through increases in social security payroll taxes and/or Federal general revenues. The second would provide most of the financing, as now, through premiums paid by employers and employees, limiting tax dollars to be used where necessary to pay for the costs of the poor and near poor. We are of strong opinion that the second principle makes the best sense for Americans at any time, especially in this particularly difficult period. Our business believes that it is not in the public interest for national health insurance to be wholly financed through Federal taxes. We reach this conclusion for the following reasons:

1. The use of such financing would make the Federal Government the sole purchaser of medical care. Such a monopoly is not desirable for the public, the providers, or the Government.

2. Americans do not want an additional tax burden. The combined employer-employee social security tax on a worker's wage has more than doubled in just 5 years. Currently, half the families in the United States are paying more in social security taxes than they are in income taxes.

3. It is essential to protect the basic OASDI system and not further complicate its problems by sweeping national health insurance into the Social Security Act. The Social Security System itself is undergoing careful scrutiny because of the fiscal problems posed by high inflation and failing birth rates.

4. Each tax dollar for health care is a tax dollar not available for other social priorities such as housing, nutrition, and ecology—all of which have a direct impact on the health of the Nation.

There are, likewise, two major contrasting principles for administering a national health insurance program. The first would have the Federal Government undertake the entire administration of the program. This would require the establishment of an enormous Federal bureaucracy. The second would provide for the fullest utilization of the existing administration and underwriting knowledge of private health insurers. We are of the firm opinion that it would make the most sense for America to utilize fully the knowledge of the private health insurance system with its vast corps of experienced personnel. This should be done with appropriate governmental supervision. We reach this conclusion for the following reasons:

1. Establishing and operating a national health insurance program is an effort of enormous scope and complexity. This requires the experienced and capable management system and personnel which is already in place, and functioning efficiently.

2. Private health insurers can do the job more efficiently than the Government. For example, the cost of administering medicare under

Social Security is about 6 percent of total claim volume. In contrast, the administrative costs of the Federal employees indemnity plan, which is operated entirely by private insurers, is less than 4 percent, exclusive of premium taxes. A recently published governmental study further confirms the greater efficiency of the private sector.

3. To wipe out an important part of the private sector of the economy, involving some half a million persons, and to replace them with a Federal bureaucracy, would be unprecedented in our Nation's history, enormously disruptive and costly. Significant destruction of business patterns with loss of jobs would be just the primary impacts.

4. Most people already have health insurance. Well over 172 million Americans (including 12 million with coverage supplementing medicare) have private health insurance as a result of aggressive and innovative plan design, underwriting, and marketing. Some 150 million have already been provided with sufficiently adequate coverage to ease the heavy financial burden of catastrophic illness, and high limit catastrophe coverage continues to grow rapidly.

The serious questions of the cost and quality of the health care that will be delivered under national health insurance must be dealt with realistically by the Congress. Quality of health care is something that cannot be mandated by fiat. Instead, it is essential that Congress exert the leadership necessary to make sure that insurance carriers, doctors, hospitals, and other health personnel work together to establish effective cost control and quality assurance mechanisms. Only then can a national health insurance program be adopted with reasonable assurance that quality care will be available at an affordable cost.

Congress and this committee are to be commended for their recognition of this factor and for their efforts to assure more manpower and to improve the health care delivery system through passage of the various manpower acts, the Health Planning and Resources Development Act, the HMO Act, and the 1975 amendments to the HMO Act recently approved by this committee.

We respectfully submit that many of the steps in the direction of a solution of this important question of cost and quality control are provided in the National Health Care Act of 1975. This act calls for the expansion or establishment of cost controls and quality assurance programs. All payments for health care under federally supported programs would be tied to prevailing charges and to peer review of those services and charges that fall outside of professionally established guidelines, assuring appropriateness of treatment, quality of care, and reasonableness of providers' charges.

The act would also help contain costs by encouraging the development of comprehensive ambulatory health care centers where primary care can be delivered on a coordinated and economical basis. By making such care available, much unnecessary use of costly inpatient hospital care can be avoided.

The act would increase the supply and improve the distribution of health care personel by adding or continuing grant and loan programs needed to train scarce health care personnel and by incentives for such personnel to serve in areas designated as health scarcity areas, including rural regions and core city areas.

This legislation would make comprehensive health insurance available to all Americans. It sets the same minimum benefit standards for all types of health insurance coverages: those provided by employers, those purchased by individuals, and those provided by a State for its financially disadvantaged residents. The benefits under these plans would be phased in over time so as not to overtax the delivery system and cause undue increases in the costs of health care.

Costs for the expenses of a catastrophic illness are covered with no dollar limit. There would be modest deductibles and copayments with a $1.000 limit on total copayment and deductible charges per family in any benefit year. For the poor and near poor, this limit would be scaled down even further.

The unemployed would be adequately covered. These individuals would be protected at their place of employment for at least 2 months after they have been laid off. If still unemployed after that period, and not capable of self-support, they would be enrolled in a State plan with the same minimum benefits as are established for employer-employee plans.

The poor and near poor would qualify for a State health care plan, which would be subsidized by the State and Federal Governments and insured by private insurance carriers. Those who are self-supporting but deemed uninsurable would be enrolled separately, with the risk covered completely by the private health insurance system.

The National Health Care Act of 1975, introduced in the Congress by Congressman Omar Burleson of Texas (H.R. 5990) and by Senator Thomas J. McIntyre of New Hampshire (S. 1438), contains the essential balance of public, governmental, and private sector participation. It is realistic. It puts tax dollars only where they have to be spent. The private sector assumes the responsibility for providing coverage for those self-supporting individuals previously deemed uninsurable. The National Health Care Act uses the tax system to encourage compliance with Federal health benefit standards. It uses private insurers for what they can do best—to provide know-how in plan design, marketing, actuarial, claims services, and working with providers in areas of cost and quality assurance. And it uses Government for what it can do best—for oversight regulation, to set standards, to provide for orderly change, to lay the groundwork for the continued pursuit of quality health care for all at a price we can afford to pay, and to provide funds for the poor and near poor.

We offer the complete cooperation and assistance of the associations which I represent in working out an appropriate national health insurance program which will be in the best interests of the American public.

[Mr. Rathgeber's prepared statement follows:]

STATEMENT OF FREDERICK E. RATHGEBER ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN LIFE INSURANCE ASSOCIATION, AND THE LIFE INSURERS CONFERENCE

THE CURRENT PERSPECTIVE WITH RESPECT TO NATIONAL HEALTH INSURANCE LEGISLATION

The primary purpose for enacting national health insurance legislation, we believe, should be to make private comprehensive insurance coverage available to all Americans so that they can have access to quality medical care at a price they can afford. This objective can be most economically and efficiently achieved by modifying and improving the current health care delivery and insurance system, rather than by destroying it and building anew, with uncertain prospects of performance and efficiency.

The debate over national health insurance is not new. There are numerous bills that have been introduced in this session of Congress that are essentially unchanged from bills introduced in the previous session and in sessions before that. The debate has, however, changed the nation's perspective. There is now a heightened sense of realism concerning national health insurance legislation. This is in part due to our growing knowledge of the complexities of the health care system and to our awareness that our national resources are severely limited, and will remain so limited for the foreseeable future. There are a number of realities which exist today that form a rather severe backdrop for discussions of national health insurance. These realities should influence the nature and shape the content of any proposal that eventually passes the Congress.

First, any proposal must carefully blend the use of essential public funds and governmental authority with the experience and proven capacities of the present health care system. The government should set standards, provide for orderly change, lay the groundwork for the faster pursuit of quality health care at a price we can afford to pay, and provide financing for the poor and near poor. Private insurers should provide their know-how in plan design, marketing, actuarial, claims service, and work with providers in areas of cost and quality assurance.

Second, it seems to us that any proposal that calls for enormous new government expenditures to be financed by new taxes of equal magnitude cannot win public support and should not be accorded serious congressional consideration. The public is not pressing Congress for increased Federal encroachment into the private sector, larger Federal budgets, larger deficits and increased taxes. It is becoming increasingly obvious that the public would like the magnitude of each of these to diminish rather than increase.

The third reality is that this country, rich as it is, does not have unlimited resources. We must allocate our resources carefully among such essentials as defense, education, the environment, food, housing, transportation, unemployment compensation, and welfare, as well as health care. A number of these areas have equal or greater impact upon health than health care per se. Health care expenditures now constitute 8.3 percent of our growing GNP, up from 5.9 percent ten years ago and 4.6 percent 20 years ago. Any national health insurance proposal must seek to cope with the ever increasing demand for health care services, some of which cannot be related to improvement in the nation's health.

A fourth reality is that in many rural and inner city areas lack of health manpower and facilities is an even greater deterrent to securing necessary health care than lack of money. Gongress and this Committee are to be commended for their recognition of this factor and for their efforts to assure more manpower and to improve the health care delivery system through passage of the various manpower acts, the Health Planning and Resources Development Act, the HMO Act, and the 1975 Amendments to the HMO Act recently approved by this Committee.

Still another reality is the coming together of views of major groups in the private sector of the health care field. The medical profession and other health care providers, insurers, employers, and an increasing proportion of the general public agree that a private insurance program, not a government monopoly of health insurance (and ultimately health care), is best with government subsidies applied only where there is no possible alternative. This developing consensus would appear to be growing in strength and commitment.

A further reality has to do with the American life style. We are a country that smokes too much, drinks to excess, lives in a success oriented-tension creating atmosphere and drives our high horse-powered cars at reckless speeds. As Fuchs has said:[1] "A great deal of what has been written recently about 'the right to health' is very misleading. It suggests that society has a supply of 'health' stored away which it can give to individuals and that it is only the niggardliness of the Administration or the ineptness of Congress or the selfishness of physicians that prevents this from happening. Such a view ignores the truth of Douglas Colman's[2] observation that 'positive health is not something that one human can hand or require of another. Positive health can be achieved only through intelligent effort on the part of each individual. Absent that effort, health professionals can only insulate the individual from the more catastrophic results of his ignorance, self-indulgence, or lack of motivation.' The notion that we can spend our way to better health is a vast oversimplification. At present there is very little that medical care can do for a lung that has been overinflated by smoking, or for a liver that has been scarred by too much alcohol, or for a skull that has been crushed in a motor accident."

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[1] Who Shall Live. Fuchs, Victor R., Basic Books, Inc., pp. 27 and 28.

[2] "National Goals and Objectives" (speech by J. Douglas Colman at National Health Forum, Chicako, Ill., Mar. 20, 1967).

Finally, there is the reality of a lack of precedent for a complete government takeover in this country of a function in the private sector, where that function has been reasonably and responsibly performed. In the recent debate on the new pension law, there was no proposal for a government takeover of the private pension business. In the current debate on no-fault insurance, there is no serious proposal to take over the auto insurance business. It would follow that there is no good reason for the government to create its own monopoly over national health insurance and eliminate private insuring organizations.

A totally government financed and administered national health insurance program is not in the public interest and would constitute a great danger to the country. The principal danger is that once we go that far, the extension of government control over all aspects of health care becomes inevitable. Once into the health area, pressures would begin to build for similar government extension into other areas of the economy. There would be no turning back. And who is to say that government can do the job better? If we are not absolutely certain of that proposition, we had better revise the present system where it needs revision rather than substituting an untried and unworkable bureaucratic government monopoly.

GOALS AND OBJECTIVES OF A NATIONAL HEALTH INSURANCE PROGRAM

The following is an outline of appropriate goals for a national health insurance program:

1. It should provide as comprehensive a scope of benefits as practical to all, regardless of income level.
2. It should allow for phasing in an expansion of coverage so that the health care system will become capable of delivering the health care expected by the population. Immediate, unlimited coverage would overburden the health care system and would result in unfulfillabel expectations, not to mention the potential inflationary impact.
3. It should address the entire matrix of national health problems. Sharply rising costs; Inadequate access to coordinated comprehensive health care for many Americans; Need for facility and manpower planning; Lack of effective, economical programs to assure quality health care and appropriate utilization thereof for all Americans; Uneven benefit levels.
4. The solutions should involve blending the expertise and strengths of all elements of the private sector with the special capabilities of Federal and State governments to set needed standards, to provide regulatory oversight, and to finance the care of the poor and near poor.
5. It should include an equitable method of financing with minimum reliance on additional federal financing, continuing reliance on private insurers, and without resort to the overburdened Social Security system.
6. It should emphasize cost effective services, with special consideration of less costly ambulatory-type care as opposed to more costly institutional care.

These goals and objectives were selected after considerable discussion over the past six years among leaders within all sectors of the health care delivery and health insurance industries. They reflect an increasing sense of realism concerning what a system of universal health insurance can be expected to achieve and what resources, above and beyond what are currently being utilized, are available for its implementation. We believe that enactment of the essential features of the National Health Care Act of 1975 would be a practical way of achieving these goals.

THE NATIONAL HEALTH CARE ACT OF 1975 (H.R. 5990)

The National Health Care Act, among the health insurance bills introduced in Congress, is best suited to achieve the aforementioned goals. First, it calls for the expansion or establishment of cost controls and quality assurance programs. All payments for health care under Federally supported programs would be tied to prevailing fees in the case of non-institutional services and to prospectively approved rates in the case of institutional services. All services would be screened against professionally established standards with professional review of those services that fall outside the standards, assuring appropriateness of treatment and quality of care. The Act would also help contain costs by encouraging the development of comprehensive ambulatory health care centers where primary care can be delivered on a coordinated and economical basis. This encouragement comes through the awarding of grants and loans for the construction and modernization of these centers. By making such care available, much unnecessary use of costly in-patient hospital care can be avoided.

The Act would increase the supply and improve the distribution of health care personnel by adding or continuing grant and loan programs needed to train scarce health care personnel and by incentives for such personnel to serve in areas designated as health scarcity areas, including rural regions and core city areas.

This legislation makes comprehensive health insurance accessible to all Americans. It sets the same minimum benefit standards for all types of health insurance policies: those provided by employers, those purchased by individuals, and those provided by a State for its financially disadvantaged residents. The benefits provided by these plans would be phased in over time so as not to overtax the delivery system and cause undue inflation. Ultimately, there would be a broad range of benefits for everyone regardless of income or physical condition.

Costs for the expenses of a catastrophic illness are covered. There is no dollar limit. There would be modest deductibles and co-payments, with a $1,000 limit on total copaymemnt and deductible charges per family in any benefit year. For the poor and near poor, this amount would be scaled down according to income.

The unemployed would be adequately covered. These individual would be protected at their place of employment for at least two months after they have been laid off. If they are still unemployed after that period and not capable of self-support, they would be enrolled in a State plan with the same minimum benefits that are established for employer-employee plans.

Among the standard plan provisions required are: provisions to continue coverage for an employee absent due to illness or injury; provisions to allow disabled dependent children to be covered; and provisions to continue coverage during employment changes.

The poor and near poor would qualify for a State health care plan, which would be subsidized by the State and Federal governments and insured by private insurance carriers. Those who are self-supporting but deemed uninsurable would be enrolled separately, with the risk covered completely by the private health insurance system.

As an inducement to employers with below average benefit plans to bring such plans up to the minimum benefit levels suggested in the Act, the bill provides that a health benefit plan which does not meet minimum standards in 1977 would lose 50 percent of its allowable income tax deduction attributable to the plan. After 1978, the deduction would be totally eliminated unless the minimum standards were met.

THE ROLE OF PRIVATE HEALTH INSURANCE

Private health insurance is now providing a valuable service to an overwhelming portion of the population as demonstrated by the fact that coverage under group and individual plans has already reached almost nine out of every ten American civilians, with a corresponding rapid expansion of the comprehensiveness of the coverage provided. The growth of such coverage has been phenomenal. In 1940, only 12 million Americans held private health insurance. Today, over 172 million (including 12 million with coverage supplementing Medicare), according to our estimates, are insured. And more than three-fourths of these insureds are covered under group plans.

Some 150 million have coverage for catastrophic health care costs either through isurance company major medical policies, high level basic policies, or through other plans. And such coverage continues to expand rapidly.

We recognize the need to continue closing the gap between those now insured and the total civilian population and to accelerate the purchase of comprehensive preventive, therapeutic and rehabilitative insurance benefits based upon Federal standards.

We also recognize the need to encourage the development of a system of health care which would provide accessibility to comprehensive protection to all, including the poor, near poor, and those previously uninsurable for health reasons.

Private health insurers, based upon the continued competition among insurance companies, Blue Cross-Blue Shield, and prepayment group practice plans assure the public of the opportunity to select plans on the basis of their relative administrative costs and the level of services received. There is evidence available which bears on the expected relative administrative costs of a health insurance program administered by the government and by the private sector.

Generally speaking, the larger the size of the group and the larger the size of the average claim the lower the administrative expense ratio. On this basis, the Medicare program, whose $10.7 billion claim volume in fiscal year 1974 was far in excess of that of any private program, should have a lower administrative expense ratio. According to the Department of Health, Education, and Welfare, the Medicare expense ratio is about 6 percent—of which 3.9% is incurred by the fiscal intermediaries and carriers and 2.1 percent by the SSA itself. Contrast this with the 3.3 percent administrative expense ratio of the privately-run Federal Employees Indemnity Benefit Plan which had an annual claim volume of about $200 million in calendar year 1973. The average administrative expense ratio for all size groups insured by private companies is only about 8 percent. These ratios are exclusive of State premium taxes and risk charges. A recently completed governmental study further confirms these findings.

Some people assert that private insurance companies make exorbitant profits. The actual fact is that profits of private health insurance companies during the last six years, while varying from company to company, have averaged less than 1 percent of premiums.

THE NEED FOR ACCOUNTABILITY

The public is entitled to expect the federal government to subject private insurance carriers to a high degree of accountability. Along with having a high level of benefits available, carrier operations, in connection with the provision of such benefits, must be appropriately supervised.

In addition, the public is entitled to the assurance that the care received meets professional standards of quality, is medically necessary, and is delivered at a cost level which is not unnecessarily inflated by wasteful practices.

To achieve these results, we propose that any universal health insurance program incorporate the following types of controls.

1. A system under which hospitals and other institutions establish rates in advance on a non-discriminatory basis with federal guidelines and with review by representatives of the public and private sectors. Experience with this type of arrangement, although limited, shows real opportunities for reduction in the rate of escalation in hospital costs. It provides to the well-run institution adequate financing to maintain and expand its services to the community.
2. Reimbursement for non-institutional providers should be based on the concept of "usual and customary" fees, administered in accordance with prevailing fee guidelines. The rate of escalation allowable should be consistent with criteria drawn from comparable measurements in the Consumer Price Index.
3. The quality of care and necessity of services to be rendered should be subject to a monitoring and evaluation system, such as the PSRO program now being implemented for Medicare and Medicaid patients. This should be expanded to cover all patients. This type of quality care evaluation should also be extended into the ambulatory care area. Such a program is essential to provide reasonable restraints on the increased demands for care.
4. Planning—Our health care resources are a national asset which must be intelligently managed if we are to get the best use out of present facilities and services, and encourage expansion on a basis which eliminates unnecessary duplication and wasteful use of manpower. The recently enacted National Health Planning and Resources Development Act of 1974 provides for broad-based community involvement in the determination of health care needs and priorities as the initial step in a coordinated strategy which encompasses local, State, and Federal agencies. The planning process will be effective only if the principles of the Act are promptly and aggressively implemented.

Representatives of the insurance industry are already involved in all of these processes. In particular, we are already heavily represented on the advisory councils, boards, and committees of areawide and Statewide planning agencies, a role we would expect to continue as the new legislation is implemented. Any national health insurance plan should continue to draw upon this expertise and experience.

Experience has demonstrated that with the enactment of legislation providing comprehensive health insurance benefits, there is a marked increase in the use of care. This, the long-range costs will be influenced by the ability to manage the increased demand so that there is improved access to care for necessary services while discouraging unnecessary services and unjustified price increases. The ineffectiveness of government alone in coming to grips with this issue is demonstrated by the following experiences:

1. In Sweden, with its system of government control and financing, health care expenditures increased by 614 percent during the period 1950–66, while the increase was 174 percent in the United States.
2. Under the compulsory insurance program in Canada, there is and has been a significantly higher hospital utilization rate than in the United States, as illustrated by 1972 figures. Utilization of general hospitals was 1,518 days per 1,000 population, in contrast with 1,178 days per 1,000 population in the United States.
3. In Great Britain, increasing criticism of the National Health Service has led to the appointment of a Royal Commission to investigate charges of overused and outmoded facilities, long waits for all but emergency medical care and widespread dissatisfaction with the system on the part of both medical care providers and the public. Despite evidence of poor performance, expenditures under the National Health Service have increased 15 percent per year between 1969 and 1973, almost twice as fast as the overall price level in Great Britain.

SUMMARY AND CONCLUSION

The private health insurance business has been doing an effective and efficient job for forty years. It is a highly competitive industry which provides a valuable service at an extremely low profit. It has the know-how to continue and expand its services under a national health insurance program. It should be permitted to do so. Any national health insurance measure that receives serious Congresssional attention now or in the future should place primary reliance and fully utilize the experience and proven capacities of the present system with only a judicious use of public funds and governmental authority.

The National Health Care Act of 1975, introduced in the Congress by Congressman Omar Burleson of Texas (H.R. 5990) and by Senator Thomas J. McIntyre of New Hampshire (S. 1438), contains the essential balance of public funds, governmental authority and private sector participation. It is realistic. Tax dollars are used only where they have to be spent. The Act phases in comprehensive benefits over time so that medical costs will not be pressured to new and higher levels. It balances a need for greater benefits for the poor with a realistic use of public funds and with an appropriate dependence on private insurers. It makes the private sector responsible for providing coverage for those self-supporting individuals previously deemed uninsurable. The National Health Care Act uses the present tax system to encourage compliance with Federal health benefit standards. It uses private insurers for what they can do best—to employ its know-how in plan design, marketing, actuarial, claims service, and provider relations in areas of cost and quality assurance. And it uses government for what it can do best—for oversight regulation, to set standards, to provide for orderly change, to lay the groundwork for the faster pursuit of quality health care for all at a price we can afford to pay, and to provide financing for the poor and near poor.

We appreciate this opportunity to express our views and pledge our full cooperation in the development of a national health insurance program which will be in the best interest of all Americans.

Mr. Rogers. Thank you very much for a very helpful statement.

Before we begin I might just say that the committee has been appreciative of the services of Mr. Pettengill and his aides in helping us prepare a dictionary of health care terms. We are grateful for that help.

Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman.

It is good to hear gentlemen with such great expertise expound on such an important subject at this time.

I noticed that you approve the 1975 HMO amendments.

Mr. Rathgeber. Yes, indeed.

Mr. Carter. What are you going to do with the people who are not covered as a result of the proposed amendments—the poor people?

Mr. Rathgeber. We realize that HMO's are not going to be able to cover everyone. The question of coverage for the poor and near poor is a very critical one and one of the essential features of the bill that we suggest. It would provide a uniform set of benefits and a method of financing for the poor and the near poor.

Mr. CARTER. Insofar as HMO's are concerned, then, you would not have them on a broadly based cross section of the American public, is that correct?

Mr. RATHGEBER. Well——

Mr. CARTER. That was the premise upon which the legislation was first established.

Mr. PETTENGILL. Mr. Carter, we would have all of our standard plans include an HMO option, including these State plans for the poor and the near poor, so that any member of the poor and the near poor could choose an HMO in lieu of the so-called indemnity benefits. The only basic premise is that the HMO must be willing to accept that individual at the same premium that the State is paying for the indemnity coverage.

Mr. CARTER. How can you reconcile that with no open enrollment, which is in these amendments we are talking about now?

Mr. PETTENGILL. There would be an open season under our plan. Under our proposal there would be one open season each year in which the poor could choose to switch from the regular State plan, which is basically an indemnity pool to the HMO, or vice versa.

Mr. CARTER. Your plan is different from the present legislation which is in the process of being adopted. The HMO amendments do not permit open enrollment at any time. Your legislation would differ from that.

Now, I notice you refer to PSRO. How is that working? You would rely on that, I notice, in your legislation, is that correct?

Mr. RATHGEBER. Yes; we hope that would be extended. That would be one of the basic forms of cost control.

Mr. CARTER. Yes, sir. You say that your legislation would affect distribution of physicians. How would it accomplish that?

Mr. RATHGEBER. There are incentives in the bill to get physicians into the medically underserved areas. There would be grants to get them to serve in those areas where they are needed the most.

Mr. CARTER. Would you provide the same assistance payments to rural physicians as you do to urban-based physicians at the present time?

Mr. RATHGEBER. Under our current insurance plans?

Mr. CARTER. Yes, sir.

Mr. RATHGEBER. It depends on the way the contracts are written. If they provide for payment based on usual and customary fees it would depend upon the level of fees in those areas.

Mr. CARTER. Well, I would say that you do not follow along that way as third party payers. It is my experience that there is discrimination against those in rural areas and I can prove it to you in certain States. You pay more to urban-based physicians. With our present setup, it is just an expensive to practice in a rural area, or even more so, than it is in an urban area. Under the system which exists today in my State, which I know about and which the doctors of Kentucky are very conversant with, rural physicians are not being paid on a par with those in urban areas. I regret to say that we have this problem at the present time.

Mr. Chairman, I reserve the balance of my time.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you. I think your statement is certainly a model of clarity in setting out the alternatives and the options. It certainly will be very helpful.

Your bill relies on the voluntary provision of health insurance by employers.

What kind of businesses would be likely just not to provide any coverage at all under the provisions of your bill? Would there be businesses that would not likely provide any sort of coverage and what would employees of these firm do?

Mr. RATHGEBER. In the first place, the bill is voluntary, but there are very strong tax incentives to encourage an employer to provide these benefits. So we think that this would be——

Mr. PREYER. Through the tax?

Mr. RATHGEBER. Through the business deduction. And this would be a very strong incentive to provide the benefits. Of course, competition among the employers would also be an incentive. But failing that, if the employer did not provide the benefits the employee could still buy individual benefits under our plan.

Mr. PREYER. Would you have any sort of guess as to what kinds of businesses or what their numbers might be who would not provide coverage under your plan, even with the tax deduction features in it?

Mr. PETTENGILL. We do not have good figures in this regard. We did try to make the best estimate we could and we have assumed 15 percent of the employers. These are the marginal employers who don't pay any income tax, where it is only luck if he makes a profit. Therefore, the deduction has no incentive for him. That is the assumption that we made in pricing our bill.

Mr. RATHGEBER. It would be 15 percent of the employers but a lot smaller percentage of the employees covered, because all of the largest employers would certainly have the coverage.

Mr. PETTENGILL. That is correct.

Mr. PREYER. But we hear a lot from constituents now who are not covered under a plan where they are employed and who are unable to get affordable health insurance on an individual basis, maybe because of some pre-existing condition one of the members of the family might have.

How would your bill address that kind of problem?

Mr. RATHGEBER. The bill provides that in every State there would have to be pools which would be underwritten by all of the carriers in that State and they would have to provide coverage for these uninsurables. There would be coverage available for everyone.

Mr. PREYER. And can there be any sort of guarantee that plan would be affordable?

Mr. RATHGEBER. Yes; there would be. The cost of these plans would be definitely within the realm of affordability.

Mr. PREYER. We hear a lot of allegations that private health insurance has failed to provide coverage for preventive health care services, that it is oriented very strongly toward acute medical care, hospitalization.

I gather that one of the arguments on catastrophic insurance, is so few people buy it. Would you like to comment on this general question of providing coverage for preventive health services and catastrophic costs?

Mr. **Rathgeber.** First, on the preventive question. This bill puts a very strong emphasis on preventive care because we feel that this is one way that you can control the costs of health care. As far as existing insurance programs are concerned, many group plans now, including some of the smaller plans, are now paying for preventive benefits, which we feel is something that should be encouraged.

As far as catastrophic coverage is concerned, we feel that this is a good way for private insurance to take care of major losses. Much of the insurance, a very large percentage of the insurance being sold today, does have catastrophic coverage. It covers an unlimited amount, or very large total amount, and in the bill we recommend there is no upper limit. It is truly catastrophe coverage, as well as providing comprehensive benefits.

Mr. **Preyer.** We have spoken earlier about people who cannot afford the insurance premium, but one problem is with the free rider who can afford it but does not take it out and then when he becomes ill he becomes a burden on society.

Does your plan provide protection against the free rider, the fellow who can afford it but will not do it?

Mr. **Rathgeber.** Only after he has exhausted his own resources in paying for his benefits and is in the category of the poor or the near poor would he be eligible to then get the subsidized coverage.

Mr. **Preyer.** It might encourage him to go ahead and take it out rather than exhaust his resources down to the poor.

Mr. **Rathgeber.** Yes; it would certainly make sense to have the coverage before he uses up his own resources.

Mr. **Preyer.** Well, let me just ask you, finally. We talked some about plans, whether they are regressive or not in their impact, and plans which rely on premiums as a major source of their financing.

Such plans have been criticized from the point of view that they shift the major share of the cost burden to the low income and, therefore, are more regressive in their impact than the kind of plan Mr. Woodcock was arguing for this morning.

Would you like to comment on the regressive feature of it?

Mr. **Rathgeber.** Yes, sir. We think this is an important principle. In this plan the premium rates are scaled according to the income levels of the poor and near poor. The amount that they pay depends upon their income. For the employed person who is contributing to his plan there is also an income related limit on how much he can pay toward his health insurance coverage. So we eliminate any regressive feature.

Mr. **Preyer.** I suppose in any health insurance bill we are not going to get something for nothing under any plan, and the first year or so in overall costs there probably will not be much difference in the different plans.

The question basically is going to be in the long run how total expenditures are going to be affected. Do you think your approach has any significantly different effect on the long-term cost of medical care in this country as contrasted with some of the other bills?

Mr. Rathgeber. Yes; we do. Of course, many of the controls that we have talked about this morning and this afternoon are in all the bills and are in everybody's thinking. The HMO's, the PSRO's, that type of thing, but we think that our bill has an additional advantage. By retaining the competition of the insurance mechanism you can also keep the administrative costs down. Once you have a single bureaucratic system you are going to increase the operating costs over the long run. We think that keeping free enterprise and competition in the picture will be good over the long run for holding the costs to reasonable limits.

Mr. Preyer. So the pluralistic system would not only affect quality of care, but costs?

Mr. Rathgeber. That is our belief; yes, sir.

Mr. Preyer. Thank you, sir, I appreciate your testimony.

Mr. Rogers. Will it be cheaper to have the program administered by the Federal Government or through the insurance company mechanism presently in existence?

Mr. Rathgeber. We believe, sir, that it would be more economical to do it through the private system, through the insurance company system, where we have had the experience, the knowledge and the competition.

Mr. Rogers. Mr. Woodcock made some statement, as I recall, that insurance companies take in about $8 billion and pay out $4 billion; I am sorry, take in $30 billion and retain $4 billion. Would that be about right?

Mr. Rathgeber. Well, I did not get all of Mr. Woodcock's figures but I think I got the general idea of what he was driving at. I would like Mr. Hemry to answer that question.

Mr. Hemry. I believe the number that was mentioned by Mr. Woodcock refers only to individual health insurance which is only 20–25 percent of the business. Most of the business is group insurance. We have compiled figures of the results of the combined individual and group business for the last 6 years, and the net profit to the companies over that period of time was slightly less than 1 percent of the premiums. So we do not consider this to be a high profit line at all—and it has been due primarily to what Mr. Rathgeber just said, the very intense competition within the business.

Mr. Rogers. What would you say is the average of the payout for amount paid in?

Mr. Hemry. In the group insurance field, and exclusive of State premium taxes which, of course, no Federal agency would be paying, it averages out at about 8 percent, thereby the payout ratio being about 92 percent.

The individual policies, which as I say, is only a small part of the business, is considerably higher than that because the expenses are necessarily higher. Putting the two together I believe we come out in the area of 10 or 11 percent expenses and the balance payout.

Mr. Rogers. I notice that a study was done by the General Accounting Office that showed administration by the insurance industry was more efficient than by social security, for instance.

Mr. Rathgeber. Yes, sir.

Mr. Rogers. Are you familiar with that study?

Mr. Rathgeber. Yes, sir.

Mr. Rogers. Do you concur in those findings?

Mr. Rathgeber. Yes; we do. We do agree, however, that it is very difficult to compare carriers on these administrative costs because the mix of business is not exactly the same in every carrier. But we do believe and concur with the general findings that the insurance carriers can administer this business and do administer it more efficiently than the Federal Government.

Mr. Rogers. I understand, too, that, as Mr. Woodcock said, for the year 1975 the cost per claim for direct reimbursement by social security was $4.11 as compared with $5.6 for the commercial insurance companies and $4.64 for the Blue Cross plans.

Are you familiar with that study?

Mr. Rathgeber. I am familiar with the statement, sir, but I have not seen the supporting evidence and I would like to reserve judgment.

Mr. Rogers. Would you let us have your comment for the record on that.

Mr. Rathgeber. Yes, sir.

[The information requested was not available to the committee at the time of printing.]

Mr. Rogers. We have had the second bells. The committee will have to recess for 10 minutes.

[Brief recess.]

Mr. Rogers. The subcommittee will come to order, please.

I think Dr. Carter had asked about mandating. You do not cover everyone, obviously, because there may be people who simply do not fit into this particular program. What happens in that instance? Is there any reason why we should not mandate health insurance coverage?

Mr. Rathgeber. This is a very debatable issue, sir, and many people feel that the best way is to mandate. We feel that voluntary insurance is a pretty good fundamental principle, that people should not be forced to carry insurance if they do not want to, and so our position is that we should start that way. We should start on a voluntary basis. If we find that there are still large gaps after that, then mandating could be the next step.

Mr. Rogers. Have we not been doing it on a voluntary basis to date?

Mr. Rathgeber. Yes; but I think the reason that so many people are not covered is not because they do not want it, but because they cannot afford it. I am thinking now of the poor and near poor, the unemployed, some of the uninsurables. I think if we can fill those gaps and get proper coverage for them that there then will be very few people who have no coverage.

Mr. Rogers. You think that necessary coverage is within the price range of most Americans?

Mr. Rathgeber. Under the present system?

Mr. Rogers. Yes.

Mr. Rathgeber. I think that very fine coverage is available for people who can afford it but there are some who just cannot. There are some whose income just cannot provide this kind of coverage and they have to be assisted.

Mr. Rogers. Is health a right?

Mr. Rathgeber. Well, we would rather say——

Mr. Rogers. Health care?

Mr. Rathgeber. We would rather say that access to good health care that is affordable is a right but that just health care itself is a matter of semantics, I think you might say.

Mr. Rogers. You told me no, did you not, really?

Mr. Rathgeber. Pardon?

Mr. Rogers. Did you not qualify it to the extent that you perhaps say; no, it is not a right?

Mr. Rathgeber. Not an unalienable right, I would say; no.

Mr. Rogers. It it not, in your opinion?

Mr. Rathgeber. I would say; no. I think everyone should have the right to get it if he can afford it and if it can be made on a reasonable basis.

Mr. Rogers. And if a person is poor but sick, there is no reason to give him care, is that what you say?

Mr. Rathgeber. I think he should have access to it on an affordable basis. We should find a way.

Mr. Rogers. If he cannot afford it at all should he have it?

Mr. Rathgeber. I think we should find a way to provide it for him on a reasonable basis.

Mr. Rogers. What is reasonable?

Mr. Rathgeber. This again, is a debatable issue, but I think that some health care is more than the Nation can afford, that there are some things that we just cannot afford to do for everybody and we must set some reasonable standards of what is proper health care.

Mr. Rogers. Do we set it on a person's income level? Is that where we draw the line as to what is affordable?

Mr. Rathgeber. No.

Mr. Rogers. Where do we draw the line?

Mr. Rathgeber. I think that, first of all, that anyone who has the means should have the right to buy as much as he wants but——

Mr. Rogers. Most of those can.

Mr. Rathgeber. Very few people can do that.

Mr. Rogers. Yes.

Mr. Rathgeber. And that the problem then is to set some reasonable level of what good health care should be and say that that is the standard for everyone.

Mr. Rogers. If the health needs go beyond that you just kind of pull the plug; is that right?

Mr. Rathgeber. There has to be a point, I think, where you cannot afford it.

Mr. Hemry. The bill which we are supporting would make health insurance available to everyone regardless of their ability to pay. If they cannot afford to pay for it then the only place you can get it is from the Government—Federal or State or both. But I think the point that Mr. Rathgeber is making is that there are absolutely no limits to the amount of medical attention, health care, if you will, that any group can absorb. There is not any limit. And, therefore, there have to be some reasonable controls on the amount of health care actually delivered in order for the system to survive. I think they found that in other countries. They are finding it in Canada. It has been mentioned a good deal today. And there just has to be some control because there is no limit to the amount of health care, that is, medical attention, that the public can absorb and this country——

Mr. MAGUIRE. I take it, the gentleman is suggesting that the limits be on the care delivered. What about limits on the cost of the care and how does your proposed bill deal with the problem of the pass-through of costs, which after all is one of the critical continuing issues in health care in this country?

Mr. HEMRY. You are quite right. We attempt to deal with that in a good deal different way than some of the other proposals. The two principal costs of health care are institutional services, such as hospitals, and professional services, such as the doctors. Our proposal provides that the institutional services, the hospital charges, will be controlled by a State commission which will pass upon the reasonableness of those charges. We feel that that is where the control should be. It should be in some sort of a State agency with consumer participation to control those charges. We have seen some States that have started in that area and have been pretty effective.

So we feel that kind of control of institutional charges, which is a high percentage of the medical care costs, is the proper approach.

On the professional charges of the medical profession, we stick with the reasonable customary charges whereby records will be kept of the prevailing charges in a particular area. This is subject to the medical professions keeping these records. And then the unusual amounts will be scrutinized individually. But again this will be done by the medical profession. The doctors are the only ones that can pass upon the reasonableness of the charges. In some cases it may be twice as much as the usual charge but it is completely justified.

The medical profession should pass on that, not some insurance company.

Mr. ROGERS. Is there any reason why hospital costs should not be on a reasonable basis, if the physician's cost is on a reasonable basis?

Mr. HEMRY. No, they would be on a reasonable basis. These State commissions that I was referring to will definitely not approve charges that are unreasonable. The hospitals will be required to submit budgets and justify any increases in the charges that they propose and this agency will pass upon them.

Mr. ROGERS. Should the physician go through the same——

Mr. HEMRY. On the physician?

Mr. ROGERS [continuing]. Process?

Mr. HEMRY. On the physicians, the proposal is that this usual reasonable and customary charge data will be compiled and then the escalation in those fees will be related to an appropriate cost-of-living factor.

Mr. ROGERS. Who makes the judgment? You say the doctors make the judgment?

Mr. HEMRY. The doctors would make the judgment as to the exceptions to the rule. I think once you get——

Mr. ROGERS. Do they make this judgment as to reasonableness?

Mr. HEMRY. Yes. That is, you keep the statistics on the charges made by the——

Mr. ROGERS. Do the hospitals make the judgment of what is reasonable?

Mr. HEMRY. No, no.

Mr. ROGERS. They would not?

Mr. HEMRY. But you see, the hospitals are in a somewhat different position in that they have budgets. They have charges and expenses that they would be required to support and justify before this State agency.

Mr. Rogers. You mean a group practice would not have a budget, generally?

Mr. Hemry. No, I think it ought to apply to a group practice.

Mr. Rogers. But not to an individual practice. Is that what you are saying?

Mr. Hemry. No. Once you get a base of the usual and customary charges in a particular area, then the escalation in charge of the individual practitioner would be related to it. The permitted escalation would be related to some sort of a price index.

Mr. Rogers. Cost of living or something like that?

Mr. Hemry. Something of that kind. It might not be just the straight CPI, it might relate to something else, but it should not be permitted to get out of hand.

Mr. Rogers. Who makes that judgment not to let it get out of hand?

Mr. Hemry. Well, that would be a part of the plan. This is not theory, this has been done in a few places and it has——

Mr. Rogers. Is there anything in your bill that brings that about?

Mr. Hemry. Yes, it is provided for in the bill.

Mr. Rogers. At what page would that be done?

Mr. Pettengill. I apologize, I was trying to find out the page. If we may, we will give you the page reference.

The point is that we do have a factor for controlling the amount of increase which physicians could make in any one period of time.

Mr. Rogers. So you are not just allowing a group to get together and set whatever is a reasonable fee; you would take a base year and have an increase according to the cost of living?

Mr. Pettengill. That is correct.

Mr. Rogers. Thank you.

Mr. Carter.

Mr. Carter. Thank you, sir.

Is it true now that under our present medicare-medicaid system the more a hospital charges, the more it is paid?

Mr. Hemry. I am afraid that is right.

Mr. Carter. Actually, we do not have much of a way of stopping that at the present time. Perhaps our PSRO rules might help out. I hope something might.

Your bill would pay 80 percent of outpatient cost, is that correct?

Mr. Pettengill. Yes.

Mr. Carter. It is unlimited hospital costs and unlimited in-patient cost?

Mr. Rathgeber. It is unlimited with 80 percent coinsurance. Then there is a limit on the total dollars that can be paid by the patient in any 1 year. In other words, there is a $100 deductible and there is $1,000 total limit on what the total expense can be for a family in 1 calendar year.

Mr. Carter. Above the thousand dollars?

Mr. Rathgeber. Yes, sir.

Mr. Carter. You take care of it?

Mr. Rathgeber. 100 percent.

Mr. Carter. One thing that I find objectionable about the present system, and I mentioned it a while ago, although in some cases you administer these plans, you are not in charge of developing the regulations which you have to follow. These regulations determine what physicians are paid or should be paid, according to the law, throughout the country. In urban areas they are paid 80 percent but in other areas they are paid only 67 percent of that amount. I think that that is quite unfair that that is done, although I know this is not your fault.

Mr. **Rathgeber.** That is the law.

Mr. **Carter.** I would like to ask you again, what would be the effect of S. 21 on your companies if it were passed?

Mr. **Hemry.** The easy answer is, we are out of business.

Mr. **Carter.** You are out of business?

Mr. **Hemry.** Out of the health insurance business.

Mr. **Carter.** You would lose how many employees?

Mr. **Hemry.** I would hope to get ahold of these numbers. I think the figure that we have used in some prior testimony has been that one-half million people would have their incomes substantially reduced.

Mr. **Rathgeber.** This was in this testimony also, if we went out of the health insurance business.

Mr. **Carter.** This would force you out of the health insurance business?

Mr. **Rathgeber.** S. 21 would. That would mean that many of our agents who now get part of their income from health insurance would lose that completely. Other people would be just out of work because 100 percent of their time is on health business.

Mr. **Carter.** Out of each dollar paid, how much do you pay out as benefit to people?

Mr. **Rathgeber.** We mentioned earlier that on group policies, which is most of the business, it is about 92 percent. On individual policies it is closer to 50 percent.

Mr. **Carter.** Thank you, Mr. Chairman. I have just one other question.

I notice that, as acting as an intermediary, that your costs in handling patients through social security is approximately 2 percent less than that of the Federal Government, is that correct?

Mr. **Rathgeber.** For the Government health plan, for Federal employees, it is somewhat comparable to what the national scheme would be. Our costs are somewhat less than 4 percent and the medicare costs have been averaging about 6.

Mr. **Carter.** Thank you very kindly.

Mr. **Rogers.** Mr. Waxman.

Mr. **Waxman.** Thank you, Mr. Chairman. There are some States which employ cost commissions to control health care costs. How effective have they been?

Mr. **Rathgeber.** I would say that they are really just getting started and I do not think that they are completely effective by any means. I think we have a long way to go to getting better control.

Mr. **Pettengill.** Connecticut has had a hospital cost control commission now for a little over 2 full years. Their first year, I believe I am correct, they were able to hold the hospitals to about a 8.6-percent increase when the Nation was going up in excess of 11. This past year they held them to 8.6, and we have not really seen what the Nation will be except it is pretty clear it is going to be over 13. So on the basis of those 2 years there is at least good hope that a State cost commission can be effective.

Now, I would be the first to admit that 2 years is not complete proof of the pudding but it certainly gives an indication.

Mr. WAXMAN. Are you monitoring these States that have cost commissions to see how they are doing?

Mr. PETTENGILL. Very definitely.

Mr. WAXMAN. I will be interested in seeing the findings of your study.

What would happen to the medicaid program under your proposal?

Mr. RATHGEBER. Medicaid would disappear. The provisions that we have for the poor and near poor with the State pools would take the place of Medicaid.

Mr. WAXMAN. Except——

Mr. PETTENGILL. Except as far as long-term custodial care is concerned. We do leave title 19 in place as far as long-term custodial care. In other words, in our judgment, custodial care is different from medicaid and has to be handled as a separate issue. It is not that it does not have to be handled, it does, but it should be handled separately from health care.

Mr. WAXMAN. Would your approach tend to favor the large insurers with group policy insurance experience? What would become of the numerous small companies providing individual insurance at the present time?

Mr. RATHGEBER. Competition would still exist. There is a place for individual insurance under our plan and for those companies that want to stay in business, they can. That is what the private enterprise system is all about. It is competitive. There is a place policy for them.

Mr. WAXMAN. Do you agree with the conclusion that your proposal would tend to favor the larger insurance companies that now have experience with group insurance?

Mr. RATHGEBER. Yes, because group insurance coverage is essentially the primary part of the plan and those who are efficient and can handle it will have an advantage.

Mr. WAXMAN. My last question is, why in contrast to H.R. 21 do you rely so heavily on cost sharing? Is this not administratively expensive? Is this not often a barrier to health care? Also would your program allow for supplementary insurance to cover coinsurance costs?

Mr. RATHGEBER. We think that there are definite advantages to both deductibles and coinsurance. We think that it does tend to keep down utilization. It keeps the patient aware of what the costs are. But there is the threshold where we get back to the 100 percent relatively quickly. When you get up to the $1,000 limit, you are into the 100-percent area. We think that the $100 deductible makes a lot of sense for keeping down the small expensive-to-administer claims and that these are two fairly reasonable ways of controlling costs.

Mr. WAXMAN. Would there be provisions for supplementary insurance?

Mr. RATHGEBER. Would there be supplementary insurance?

Mr. WAXMAN. Yes. Would such insurance be available?

Mr. RATHGEBER. This is not something that we specify. Perhaps it would be, there would be carriers who would want to provide that.

Mr. WAXMAN. If there is supplementary insurance would that not defeat the purpose of controlling costs by requiring copayments?

Mr. RATHGEBER. It is possible, but whoever has it has to pay for it, so they are paying for it one way or another.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. ROGERS. Should we require a minimum benefit package in every health insurance policy sold in America?

Mr. RATHGEBER. It depends on what you mean by require. In our case we set a minimum standard which would qualify as a plan to get the tax deductions, so in that sense, it is required. We think that that is a very sound principle.

Mr. ROGERS. We have another vote. I am afraid the subcommittee is going to have to adjourn for about 10 minutes; we will try to finish you up shortly. I know you have planes to catch.

Mr. RATHGEBER. Thank you, sir.

Mr. ROGERS. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

What are the provisions in your bill that go to the distribution of manpower and how would those function?

Mr. PETTENGILL. Basically, sir, we have been sympathetic with the work which you and your committee have been doing. Our feeling was that there did need to be more emphasis on the training of people who would be involved in preventive and primary care and people who would be involved in the comprehensive health care centers. Therefore, the bill provides for grants and loans to those people, with a loan forgiveness provision for service in an area of short supply.

In addition, as Mr. Rathgeber mentioned earlier, there is provision for actual incentive grants to existing physicians to serve in areas of short supply.

May I say that we did find on page 62 the reference which you requested as to the limitation on the amount by which physicians may be permitted to escalate in any year.

Mr. ROGERS. Thank you. Very helpful.

Where would the money come from to be applied to the manpower situation?

Mr. PETTENGILL. These would be additional general revenue funds and in the fiscal year 1977 we estimate them to be approximately $400 million.

Mr. ROGERS. Now, if your bill were to be passed, when would it take effect? Next year? When would it actually take effect?

Mr. PETTENGILL. As you appreciate, there are various provisions of the bill and as far as the manpower and the comprehensive health care centers are concerned, those funds would be made available immediately.

As far as the standard benefits are concerned, we visualize that there would be approximately a 2-year lag between passage and the start.

Mr. ROGERS. What would you do about health facilities?

Mr. PETTENGILL. Essentially, our feeling is that the existing law provides pretty good funds as far as inpatient facilities are concerned and that the need is for additional funds to encourage the development of comprehensive ambulatory care centers. So we support a modest amount in the bill for loans to such proposed institutions.

Mr. ROGERS. Would there be any grants?

Mr. PETTENGILL. I am sorry, I would have to doublecheck. It could be both grants and loans. I would have to doublecheck.

Yes; it is both.

Mr. ROGERS. And the moneys would come from the General Treasury?

Mr. PETTENGILL. Yes, sir, again from the General Treasury; $200 million for that purpose.

Mr. RATHGEBER. That is included in the $400 million Mr. Pettengill mentioned.

Mr. ROGERS. Four hundred?

Mr. RATHGEBER. The total is 400.

Mr. ROGERS. That would be for facilities?

Mr. RATHGEBER. And for the personnel.

Mr. ROGERS. Two hundred would be for manpower.

Does any of this go for training?

Mr. PETTENGILL. The 200 we are talking about here is simply for the bricks and mortar and the equipment of the ambulatory care center. Back in the other manpower section are grants and loans for the individuals who would operate those centers.

Mr. ROGERS. Do you do anything for the training of manpower?

Mr. PETTENGILL. Yes.

Mr. ROGERS. Paramedical?

Mr. PETTENGILL. There are additional moneys for schools which would set up programs to train these people.

Mr. ROGERS. Train doctors, dentists, and so forth?

Mr. PETTENGILL. Correct.

Mr. ROGERS. Nurses?

Mr. PETTENGILL. Yes, sir.

Mr. ROGERS. How much would that be?

Mr. PETTENGILL. For the physicans and dentists, $50 million; for nurses, $40 million; for allied health professionals, between grants and loans, $26 million; for the medical schools in terms of setting up training programs, $25 million; and for grants to physicians who would go to depressed areas, $50 million. That is per year.

Mr. ROGERS. Have you projected what the impact of those sums might be in the production of manpower?

Mr. PETTENGILL. Admittedly, they are modest but we wanted to be sure that the systems were working properly before we had the Nation expend undue amounts.

Mr. ROGERS. Of course, you realize there are ongoing programs in this regard?

Mr. PETTENGILL. Yes; these amounts I am talking about are in addition to the amounts which you have already authorized.

Mr. ROGERS. So that you would continue the present programs but simply add this to them?

Mr. PETTENGILL. That is correct.

Mr. ROGERS. I see.

Would this be true in regard to facilities as well?

Mr. PETTENGILL. Yes, sir.

Mr. Rogers. So it would be in addition to what we are presently providing for facilities.

What do you do as far as the planning process is concerned? Do you take advantage of the present bill that has just been passed and is now being implemented, or do you address that?

Mr. Pettengill. In years past we have had a section on comprehensive health planning but we were sufficiently impressed with the current bill that we felt it should be given an opportunity to be tried. Therefore, there is nothing other than a reinforcement of that bill. In other words, throughout the bill, with regard to decision as to what is an area of short supply and what is needed, they must all have approval of the appropriate health system agencies.

Mr. Rogers. So it is geared into the planning bill?

Mr. Pettengill. Yes, sir.

Mr. Rathgeber. We fully support that bill, yes, sir.

Mr. Hemry. Just to supplement that a little. You should know that we, as an association, are making a major effort to get insurance people and others involved in these HSA's and the planning process because we feel it is very important and that there ought to be that kind of participation.

Mr. Rogers. What about training, do you have any provision in your plan of health policies that would include a percentage of those policies for the training of personnel such as residencies, internships and so forth, in hospitals?

Mr. Pettengill. No; we did not take a percentage of the premium and allocate it to developmental resources of either manpower or facilities. We felt that frankly, those moneys should be determined separately from the premiums for the benefits themselves.

Mr. Rogers. Well, for instance, when patients go into a hospital they often derive certain care in many centers, from residents that are in training, and so forth, but there is no reimbursement for those services per se, the hospital has to bear that, as you know.

Mr. Pettengill. In Connecticut, for example, where I can speak from first-hand experience, the Connecticut Hospital Commission does recognize the salaries which are paid to interns and residents as a legitimate cost of the hospital and so in determining the approved budget and hence, the approved scale of charges that a hospital may use, those particular expenses are taken into account. They have not, however, included the so-called research expenditures of hospitals.

Mr. Rogers. In Connecticut your policy does cover that in that that is included in the cost as presented for you to pay?

Mr. Pettengill. That is correct.

Mr. Rogers. I noticed you mentioned you would bring in some benefits, now. You crank them in in steps, as I recall. Could you let us know what benefits you would bring in, say, the first year? I guess that would be actually the second year of the program?

Mr. Pettengill. Yes, sir. One second. Starting on page 32 of the bill and running through page 36 are the list of covered expenses, and as we have indicated, starting on page 31, those which we classify as category 1 would be paid at the rate of 80 percent after a $100 deductible. Those in category 2 which would be paid at a rate of 100 percent without any deductible, after the year 1985. They would be subject initially to the deductible and copayment.

I should also make it clear that the deductible would be increased each year in proportion to the increase in the consumer price index.

Mr. ROGERS. The deductible would?

Mr. PETTENGILL. Yes.

Mr. ROGERS. Would the policy cost also increase?

Mr. PETTENGILL. It goes——

Mr. ROGERS. According to the consumer index?

Mr. PETTENGILL. No, sir, the cost for the particular benefit for a particular policyholder would be on the basis, normally, if he was a larger employer, his own experience. In other words, his case would be experience rating.

As far as small groups are concerned, each carrier sets up its own pool and all employers in that carrier's pool for small employers are paying the same scale of rates. We visualize quite frankly, that the pool for the uninsurables would be paying a similar rate, perhaps a slightly higher rate, but not significantly higher.

Mr. HEMRY. In connection with the benefits listed in the bill, I think we should make it clear that these are in effect, illustrative rather than benefits that we have determined should be in, so that if the Congress determines that there should be a phasing over a longer period, perhaps starting at a lower level in order to hold the price of the bill down, that would be perfectly agreeable to us. We felt that in order to have a complete bill we ought to have the benefits specified, which we have done, but we are not wedded to that particular schedule of benefits.

Mr. ROGERS. Now, I presume you cover inpatient and outpatient?

Mr. HEMRY. Yes, sir.

Mr. ROGERS. And all major surgical?

Mr. HEMRY. Yes, sir.

Mr. ROGERS. Do you have a limit on the amount to be paid?

Mr. HEMRY. No.

Mr. PETTENGILL. We basically have unlimited coverage, sir, except as regards a skilled nursing facility, where we have a limit of 180 days in a year. That 180 days was our best judgment of the point beyond which stays would probably involve custodial care as against medical care.

We would accept the committee's judgment as to what that exact period should be but our experience in the areas of ambulatory mental and nervous care, psychiatric care, give us the feeling that there comes a time in that care where it does border on the custodial. We do not have the wisdom of Solomon but we do feel that some limit has to be established.

Mr. ROGERS. What about diagnostic services?

Mr. PETTENGILL. Diagnostic services are covered and are initially subject to the deductible and coinsurance. But in the second phase, which we propose to be 7 years later, but which can be whatever you deem appropriate, we suggest and recommend to you that the deductible and copayments be waived for diagnostic services on an ambulatory basis. The same is true of well-child care, of children's dental services, children's eye examinations, family counseling, and a Pap smear for women.

Mr. ROGERS. What about diagnostic X-ray and laboratory tests performed other than while an inpatient in a hospital or skilled nursing facility?

Mr. Pettengill. What we are saying is they should be covered immediately subject to the deductible and copayment but after some reasonable period of time; that is, as quickly as you think it is feasible, those services should be exempt from any deductible and copayment in order to encourage their utilization.

Mr. Rogers. But in the category 1 you have X-ray and laboratory diagnostic?

Mr. Pettengill. All X-ray and labs are covered but they are subject to——

Mr. Rogers. $100 deductible?

Mr. Pettengill. Yes, sir.

Mr. Rogers. What is the cost of the policy?

Mr. Pettengill. We estimate that for the first fiscal year, speaking now for the employed people, not for the poor, from whom there is a varying scale of deductible and limits—but speaking for the typical employed individual, we estimate that the cost per child is $134 a year, per adult under 65, $370 a year, and to bring the medicare benefits up to this level would cost for medicare eligible an additional $248.

Very quickly, sir, a single adult is $370 a year, a man and wife and two children would be $1,000 a year.

Mr. Rogers. Could you break that package down as to what the cost would be to an employer and to his employee per person and by family?

Mr. Pettengill. The employee limits on employee contributions would be the lesser of the actual premium or 10 percent of his pay for the preceding month by that employer over the definition of poverty, whatever you adopt.

For example, we have said that for a man and his wife utter poverty would be earning less than $250 a month or $3,000 a year. So that if this employer were paying a man or woman with a spouse less than $250 a month, in wages, then that employee would not be required to contribute 1 penny to the cost of these standard benefits.

Mr. Rogers. Who pays it?

Mr. Pettengill. The employer would be obligated to pick up the excess.

Mr. Rogers. So, anyone who does not pay at least $250—would that be combined husband and wife or for each?

Mr. Pettengill. That is the combined.

Mr. Rogers. Then the employer would pay for it?

Mr. Pettengill. The employer in that case would be picking up the entire premium.

On the other hand, for an individual who was making, let us say, $2,000 a month, you subtract the $250, that leaves $1,750. 10 percent of that is $175, as you can see. That is more than the whole premium. So, theoretically, somebody earning $24,000 a year could be charged the entire premium, if the employer wanted to. As a practical matter, I think you realize half of all of the plans in the United States are noncontributory today.

Mr. Rogers. What is the average cost of the plans today?

Mr. Pettengill. Today? I believe we do have a figure in here.

Mr. Rogers. Give us a general figure.

Mr. Pettengill. We estimated that in fiscal year 1977 the average employer would be paying $481 per employee for both the combined employee dependence coverage before enactment of these benefits. That if you enact these benefits and if every employer bought them, then you would move up to $521.

Mr. ROGERS. I see. What about to a self-employed individual?

Mr. PETTENGILL. The self-employed individual would be purchasing an individual policy. We rather anticipate that because the average benefit that the individual policy would be providing would be so much greater than it is today that commissions would be held at approximately the same dollar level and hence, drop sharply as a percentage, so that probably the individual would be buying the policy at about 125 percent of cost instead of the present 200 percent of cost.

Mr. ROGERS. What would that average now?

Mr. PETTENGILL. Well, today I doubt very much that the individual policy runs in terms of purchasing more than $200 to $250 a month. As a consequence the benefits purchased are quite modest.

Mr. ROGERS. What would it be under category 1?

Mr. PETTENGILL. Under this new program, of course, it would still be up to the individual company to set its rates except for the proviso. Those rates could not as a parctical matter exceed the rate for the pool for the uninsurable because obviously, if you start to charge me more than the rate for an uninsurable I will buy from the pool.

Mr. ROGERS. And what is that limit?

Mr. PETTENGILL. That is not specifically set in the law, sir, it is left up to the negotiations between the carriers and the State Insurance Commissioner.

Mr. ROGERS. What would you anticipate?

Mr. PETTENGILL. I would anticipate that it would be somewhere between 125 percent and 150 percent of the typical group rate for a 10 life case.

Mr. ROGERS. What is your estimate for a poor person, what would be the cost there?

Mr. PETTENGILL. In the initial years, because our poor people, unfortunately, have not been educated to use health care, I think that you could anticipate that the initial cost would probably be somewhat the same as the employer's cost. I would anticipate that you would have a rise during the few years as we hopefully educate these people to use the system more appropriately. On the other hand, once we got them to use the system hopefully, we would take care of a lot of their acute problems and then it would drop back down.

So, we really think that the State pools for the poor and near poor will run no higher than the pools for the uninsurables, in fact, should run a little less.

Mr. ROGERS. What would that be, $1,000?

Mr. PETTENGILL. For your family of four, probably in the neighborhood of $1,200.

Mr. ROGERS. About $1,200 for the family of four?

Mr. PETTENGILL. Yes, sir.

Mr. RATHGEBER. We should add that this cost is scaled according to the income of the individual and——

Mr. ROGERS. This is the poor person that does not have any.

Mr. RATHGEBER. That is what I am talking about. If he is below that level he would pay nothing and it is scaled up according to his income.

Mr. ROGERS. Who pays it, the State, I presume?

Mr. RATHGEBER. Yes; the total cost.

Mr. Rogers. I was wondering what was the cost?

Mr. Rathgeber. The difference is paid by State and Federal Government.

Mr. Pettengill. I was talking to you in terms of the total cost.

Now, the individual pays a piece which is related to his income. Below a certain income he pays nothing. Then the State pays the carriers chosen the balance of the premium. The State in turn would receive from the Federal Government assistance along the same lines as the present medicaid program but at a higher level. We would have a minimum Federal payment to the State of 70 percent and running up to 93 percent.

Mr. Rogers. That is what you would pay?

Mr. Pettengill. That is what we would propose.

Mr. Rogers. I see.

Now, what about category 2, what increased costs that would be brought about by category 2 when phase that in in 1985?

Mr. Pettengill. I will have to submit you a statement on that and it would have to be, sir, in terms of fiscal year 1977 cost because I do not think I would dare predict what 1985 costs will be.

Mr. Rogers. Could you give us a rough estimate now of what you think it might be in terms of a percentage increase over the figures you have given us?

Mr. Pettengill. Basically, what we are doing is taking those items which are entitled category 2 in the bill and removing those out from under the deductible and eliminating the copayment, and my offhand reaction is that this is somewhere in the neighborhood of a 10-percent increase.

Mr. Rogers. Increase?

Mr. Pettengill. Yes.

Mr. Rogers. When you cranked in category 2?

Mr. Pettengill. Right. I am sorry, sir; I was thinking just of those pieces. The whole thing is in the neighborhood of 30 percent because we have certain other items. We have some dental for the adults which does not come in until category 2. So we are talking about a 30-percent increase in the category 2.

Mr. Rogers. Now, if you had no cost sharing, what percentage of change would come about in your premuiums?

Mr. Pettengill. This is admittedly a most difficult question to answer. There is no question, since we are talking about an 80-percent rate of payment, that you are going to have at least a 25-percent increase because it takes 80 times 1.25 to equal 100. But, the experience of Great Britain and other countries which have tried to provide free care have indicated that the utilization rate goes up. This is the unanswerable question. How much beyond the 25 percent would you have to allow? Quite frankly, I do not think there is anyone that can give you that answer except to tell you that it would depend in very large measure on the ability of your professional standard review organization and your other utilization review organization. I really feel that this would be a tremendous load on them and that for small items such as the one drug or the one office visit you really could get a very substantial increase in utilization that nobody could put their fingers on.

Mr. Rogers. We have been told that the Canadian system has not experienced overutilization. There was an increase right at first but it has calmed down. Has that been your experience witnessing the Canadian system?

Mr. PETTENGILL. I think you have to realize that the Canadians have not yet introduced either prescription drugs or dental benefits so that, in other words, the Canadian system covers hospital under one plan and physicians under another. They are not yet talking about as comprehensive a plan as we are talking about here.

Mr. ROGERS. Do you include dental care in your plan?

Mr. PETTENGILL. We include dental care for——

Mr. ROGERS. For adults?

Mr. PETTENGILL [continuing]. For children initially, and for both children and adults ultimately.

Mr. ROGERS. When?

Mr. PETTENGILL. 1985 for adults.

Mr. ROGERS. All dental care?

Mr. PETTENGILL. All except orthodontia.

Mr. ROGERS. What about mental health?

Mr. PETTENGILL. Mental illness is covered except we do feel on ambulatory care there should be some limitation on the number of visits per year. I believe the bill has a limit of 20.

Mr. ROGERS. Twenty visits a year?

Mr. PETTENGILL. Per year.

Mr. ROGERS. Let me ask you about your proposal. As I understand it, you believe that the hospitals and other institutions should establish rates in advance on a nondiscriminatory basis?

Mr. PETTENGILL. That is correct.

Mr. ROGERS. General guidelines and review?

Mr. PETTENGILL. These would be filed with a State agency which would review them.

Mr. ROGERS. It is almost the budget idea that we presented today on institutions, is it not?

Mr. PETTENGILL. Except that we are not setting a total budget from on high which goes down. In other words, we are permitting the hospital to present its best estimate of what it needs for a budget and then having the State agency look at all of those various budgets.

Mr. ROGERS. But the final decision is made by the State, not by the institution, is it not? I understood you to say that.

Mr. PETTENGILL. That is correct.

Mr. ROGERS. Well, instead of the region doing it, you have the State doing it?

Mr. PETTENGILL. That is correct.

Mr. ROGERS. That is very similar, those two approaches.

Now, reimbursement, you agree, could be by the usual customary and reasonable fee?

Mr. RATHGEBER. They have the total dollar limit again.

Mr. ROGERS. From the top?

Mr. RATHGEBER. For the providers, which we do not.

Mr. ROGERS. And the rate of escalation should be drawn from the Consumer Price Index. I think they do the same thing do they not? You start with usual and customary and then allow the price increase?

Mr. PETTENGILL. We hope——

Mr. ROGERS. With the index?

Mr. PETTENGILL. We hope we have chosen an index which is a little bit more reflective of the physicians costs than the straight CPI.

Mr. ROGERS. All right. And there is some similarity there, the same basic approach. Not everything would be, you are saying?

Mr. PETTENGILL. That is right.

Mr. ROGERS. Judgments would be made about the quality of care and the necessity of services rendered. You also agree with the PSRO monitoring utilization committees and so forth?

Mr. PETTENGILL. Must be extended to the entire population.

Mr. ROGERS. So I think there is a similarity there. I was just wondering how these are similar.

Then I believe you also support the planning concepts—certificate of need and review of facilities?

Mr. PETTENGILL. Right.

Mr. ROGERS. And what about certificate of need for existing services? Should they be looked at and that problem addressed, if there are duplicative services or——

Mr. PETTENGILL. We feel that your new law, sir, gives the——

Mr. ROGERS. Lays a foundation?

Mr. PETTENGILL. Gives the State power to eliminate the gross duplication, not that this is going to be easy. It is not.

Mr. ROGERS. I see some similarities. Now, I think the difference is how we pay for services and who we use to administer them. I think you should document for us the cost of administration. If you would compare the benefits you are suggesting and the benefits others are suggesting, and let us have some comparison there, I think it would be helpful, including what the comparable costs would be if you had a single set of benefits. You could take one bill and work it through, take your bill and work it through, if that is possible, and let us have the comparable costs. I think that might be helpful.

[The information requested was not available to the committee at the time of printing.

Mr. ROGERS. I notice you say that in Canada they have more general hospital use than we do in this country, even though they have a national health insurance plan. So I presume over-use is a problem even in Canada.

Do you know if Mr. Burleson is still interested in his program?

Mr. RATHGEBER. He very definitely is, yes, sir.

Mr. ROGERS. I wondered about it. I did not see him here and I wondered if he were interested in having this committee consider his proposal.

Would you let us have a statement from him as to whether he is still interested in this program or not?

Mr. RATHGEBER. Yes; I know he is interested because——

Mr. ROGERS. I did not see him here today and I wondered.

We will get back to you with more specific questions. This gives us a brief summary for the record.

You have been most patient with us and we apologize for keeping you so late.

Thank you for your help and cooperation with the committee and we look forward to working with you and in trying to solve the national health insurance problem.

The committee stands adjourned until 2 o'clock tomorrow afternoon.

[Whereupon, at 4:45 p.m., the committee adjourned, to reconvene at 2 p.m., Tuesday, December 9, 1975.]

NATIONAL HEALTH INSURANCE

Major Proposals

TUESDAY, DECEMBER 9, 1975

House of Representatives,
Subcommittee on Health and the Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:30 p.m., in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. Rogers. The subcommittee will come to order, please.

This will be a continuation of our hearings on national health insurance proposals.

We are very pleased this afternoon to have one of our own members—the ranking minority member, Hon. Tim Lee Carter of Kentucky, to share with the committee his thinking on this important subject. He has authored a bill, so I know that his testimony will be most helpful, especially to this committee in its deliberations on health insurance issues.

We are grateful to you for being here, and you may proceed as you desire. If you like, your statement will be made a part of the record in full at this point.

STATEMENT OF HON. TIM LEE CARTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. Carter. I will keep it quite short, Mr. Chairman. Thank you. I am pleased that you have arranged for the Subcommittee on Health and the Environment to hold hearings on the topic of national health insurance. It is a most important and timely issue, which deserves the subcommittee's careful consideration.

I welcome the opportunity to testify on behalf of my bill, H.R. 4747,[1] the comprehensive health insurance plan, which I introduced in March of this year. It is, in essence, the administration's 1974 "CHIP" proposal—with the addition of what I consider to be a very significant section—a preventive services package—about which I will say more later.

In reviewing this proposal, with my new section, I want to remind my colleagues that the President has clearly and repeatedly stated his opposition to enactment this year of new spending programs, even though the programs would call for no expenditures during this year. I understand and fully respect the President's position.

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[1] See p. 679 for full text of H.R. 4747.

Yet, at a time when there will soon be much discussion of national health insurance, I believe that the Congress should formally have before it this thoughtful proposal, with its new preventive medical services section, so that it may be considered in debate with other proposals which have been developed to address the cluster of concerns referred to as our national health-care crisis.

At this point, Mr. Chairman, in the interest of time, I will submit for the record a detailed explanation of the 1974 CHIP proposal, with a section-by-section analysis prepared by HEW.

Mr. Rogers. Without objection, it will be received. [See p. 118.]

Mr. Carter. Now, I will briefly review the main features of the CHIP proposal and then proceed with a discussion of the preventive services package which I have added to that proposal this year. I feel it is this addition which makes the CHIP proposal a truly comprehensive national health insurance plan.

The CHIP proposal is built upon a number of principles which I feel should govern our approach in the development of a national health insurance program. These include:

(1) Universal and voluntary participation.

(2) Comprehensive and uniform benefits.

(3) Building on the strengths of the private health care system.

(4) Dependence on private funding.

(5) Reliance on a private/public partnership for implementation.

(6) Structuring of controls and incentives to improve the delivery of health care services.

(7) Maintaining a pluralistic health care system.

Based on my revision of the CHIP proposal, I offer another guiding principle, which, I believe, is equally important—that of supporting a preventive approach to health care which would not only help prevent disease, but which could also help control costs.

H.R. 4747 draws upon these guiding principles by providing the opportunity for every American to buy comprehensive health insurance at rates which are affordable.

Under the CHIP plan, every American may obtain the same health insurance coverage under one of three plans: The employee health insurance plan (EHIP); the assisted health insurance plan (AHIP); or medicare.

Under the employee health insurance plan (EHIP), all employers would be required to offer the basic insurance plan—and available prepaid health care plans—to each employee under age 65 who has met the full-time hours of work test. Coverage would extend to family members under 65, and election of coverage would be voluntary at the option of the employee. Under EHIP, all employers would pay at least 75 percent of the premiums except for the first 3 years when they pay 65 percent.

The assisted health insurance plan (AHIP) would cover those persons under 65 who are ineligible for EHIP or who find it economically advantageous to join AHIP. Under AHIP, low income persons will be provided an opportunity to obtain health insurance coverage according to ability to pay. The plan would be administered by the States through private carriers and financed by premium contributions from covered persons, and from Federal and State general revenues.

The third program, medicare for the aged, would be retained for all persons over 65 years of age. The benefits would be the same as the health services of the other two plans, thus improving the benefits of the present medicare program. The plan would be administered in a manner similar to the current program.

Regardless of which plan they are covered under, all Americans will have identical health benefits. These benefits include:

Unlimited inpatient hospital services, physician services, and prescription drugs; 100 home health visits per year; 100 days of posthospital skilled nursing facility services per year; blood and blood products; routine medical items and services such as prosthetic devices, dialysis equipment and supplies; X-rays, laboratory work; ambulance services; mental health services, including outpatient visits to private practitioners, and services at comprehensive community care centers; maternity and well-child care; prenatal care; family planning services; and preventive medical services provided at certain ages.

It is this last section—the preventive medical services—which significantly expands the original CHIP proposal's preventive provision. I believe that the extensive preventive services package, which I have included in H.R. 4747, is a unique and innovative feature of the bill which merits careful consideration.

Before describing these services, I would like to develop, for a moment, this idea of prevention. As a practicing physician for many years, I am well aware of the value of a preventive approach to health care and the need for its inclusion in a comprehensive health care program. I am convinced that prevention has greater long-range health value than many other kinds of health services and that it may ultimately result in reducing the cost of all services.

I believe that a national health insurance program should not only help to protect people against the cost of caring for sickness but it should help advance, maintain, and promote health by heading off illness before it can start. For these reasons, I have added this preventive services package to the CHIP proposal. It draws upon the knowledge we have of preventive medicine which informs us of many specific procedures which should be carried out at various times of life to protect health. The strategy I have devised will apply certain of these procedures at those periods of life when they will be most appropriate and effective. Thus, I have consolidated preventive services as follows:

Maternity and prenatal items and services;

Normal and high-risk infant care for individuals between the time of birth and 1 year of age;

School entry assessment for individuals between the ages of 5 and 6;

Puberty assessment for individuals between the ages of 12 and 14;

Adult entry assessment for individuals between the ages of 17 and 19;

Young adult assessment for individuals between the ages of 24 and 26 years and for every 5 years thereafter until the age of 44;

Middle-age assessment for individuals 44 to 46 years of age and for every 5 years thereafter until the age of 59;

And older-age assessment for individuals 59 to 61 years of age and every 2 years thereafter.

For example, in the case of normal infants and high-risk infants between the time of birth and 1 year of age, we would generally provide four visits—six visits for high-risk infants—to physicians or physician supervised assistants for observation and measurement of growth and development. This would include a complete immunization schedule and parent counseling, and other measures to assure the necessary followup of abnormalities. There would also be parent counseling available for a discussion of appropriate nutrition, hygiene, behavior, and possible accidents.

As another example, for the adult entry assessment of individuals between the ages of 17 and 19, we would provide the following:

First, health examinations—including the measurement of height and weight, the taking of blood pressure, vision, hearing, and dental examinations. In addition, there would be appropriate laboratory tests such as blood cholesterol, urine-sugar and albumen, and a culture for gonorrhea—for females—and VDRL; second, there would be counseling services, including counseling respecting family planning, genetic problems, and hazards of daily living such as alcohol and drugs.

These are just two examples of the extent of services which would be available in the preventive services package. I think it is particularly significant to add, at this point, that there be no deductible of or coinsurance for the preventive medical services. Individuals would be encouraged, rather than discouraged to seek out preventive services.

The comprehensiveness of H.R. 4747, with its preventive medical services and catastrophic benefit packages, might suggest runaway, astronomic costs. However, with this concern in mind, a number of cost-control measures have been incorporated into the bill.

These include the most reliable method of cost-containment, which is consumer cost consciousness. One of the plan's basic features is the inclusion of premium and cost-sharing requirements, which, while reasonable, are high enough to deter unnecessary overutilization of health resources. Each person and family covered under EHIP, AHIP, or medicare would have a deductible which would have to be met before his or her insurance coverage would pay for costs incurred. This minimum deductible would range from $0 to $150, depending on a person's or family's ability to pay.

There would in addition be a separate deductible for outpatient prescription drugs which would range from $0 to $50, and coinsurance rates of 10 to 25 percent. Each person with EHIP, AHIP, or medicare coverage would pay coinsurance until a maximum liability had been reached beyond which all expenses would be paid by the insurance policy. The maximum liability ranges from $150 for a family with an annual income below $2,500 to $1,500 for families with $10,000 or more of income. As I mentioned before, there would be no deductible or coinsurance for the preventive medical services. The total cost to the Federal Government will be a small price to pay for the benefit of assuring all Americans the opportunity to obtain comprehensive and catastrophic health insurance coverage at affordable rates.

Mr. Chairman, there are many other provisions in this bill which I will not discuss today due to time constraints. This proposal is a comprehensive piece of legislation, which I believe represents a workable and appropriate approach to the crucial problem of assuring opportunity to every citizen for meeting his or her health care needs.

However, I must add a qualification to that statement. I am well aware, as are my colleagues, I'm sure, of the need to put national health insurance in proper perspective, within the total context of this Nation's concerns. I realize that whatever form a national health insurance program may take, it cannot, in isolation, assure a high level of health in this country. A host of conditions, which are problems of our modern society, such as pollution, housing, inadequate diet, low income, stress and strain, all contribute to the health, or actual ill-health of our citizenry. However I am hopeful that in addition to designing a truly comprehensive health insurance program, this Congress will continue to address these other pressing areas of concern, so that the ultimate effect of a national health insurance program will be maximized in every way possible.

Thank you, Mr. Chairman.

[The CHIP proposal and summary of H.R. 4747 follows:]

ORIGINAL 1974 CHIP PROPOSAL

General Concept and Approach

The proposal would establish a three-part national program including (1) an employee health care benefits program requiring employers to offer specified private health insurance to their employees, (2) a State-operated assisted health care program providing coverage for low-income families and for families and employment groups who are high medical risks for health insurance, and (3) a Federal health care program for aged persons, representing in effect an expanded Medicare program. All programs would offer the same scope of health services and provide protection against the costs of catastrophic illness.

The State governments would have major responsibility for the supervision of the employee program, administration of its assisted health insurance program, and the regulation of insurance carriers and providers of health services--all in accordance with Federal guidelines or rules.

The program includes provisions to facilitate enrollment in prepaid practice plans by providing an option for persons under all plans of the proposal to enroll in prepaid plans. Also, a new system of reimbursement of providers of health services would be established under the program.

EMPLOYEE HEALTH CARE INSURANCE PLAN

The employee plan would require employers to make available to their full-time employees a health care benefits plan providing a broad range of hospital, medical, and preventive services and protection against catastrophic illness. Coverage would be implemented through private health insurance and financed through employer and employee premium contributions, with temporary Federal subsidies for firms with unusually high increases in premium costs.

Coverage

Employers with one or more eligible full-time employees--measured by a test of number of weeks and hours of work--would be required to offer coverage and contribute toward the premium for a health care plan covering the employee and his family. To qualify as an eligible full-time employee, the employee must work for (a) at least 25 hours per week for at least 10 weeks or (b) a total of 350 hours, in the preceding 13-week period. Thus, for a new 40-hour-week worker, coverage with full employer contributions would start during the ninth week of employment (that is, after 350 hours of work).

However, if an employer is already providing coverage under these regular provisions, any employee working 25 hours a week could elect coverage (starting in the following week) by paying the full premium himself at the group premium rate.

The law would apply to all employers (as employer is defined by the common law) and would include State and local governments, but not the Federal Government or agencies of foreign governments or international organizations. Employees age 65 and over and aged members of an employee's family would not be eligible under the employee plan. For eligible employees, participation in the plan would be voluntary.

Continuation of Coverage

Coverage under an employee benefit plan, with full employer contributions, would continue for at least 90 days after termination of work. It could continue an additional 90 days, at the option of the employee, with the employee paying the entire premium at the group premium rate. These 180 days of additional coverage would provide protection during periods of unemployment, the beginning period of a new job, and periods of disability.

Benefit Structure

The required benefits under an employee health care plan include hospital, skilled nursing facilities, physicians, home health, and diagnostic services, and such additional benefits as prescription drugs, preventive care, and special services for children.

A plan could not exclude benefits for preexisting medical conditions, require any waiting period before benefits become payable, or impose any maximum limit on the total amount of benefits payable on an annual, lifetime, or any other basis. The required basic benefits are shown in table 1.

TABLE 1.--Covered services under the proposal

Type of service	Limit on benefits	Other information
Institutional services		
Hospital inpatient	No limit	Special limitations for mental illness.
Skilled nursing facilities	100 days per year	Available after a hospital stay of 3 days or more.
Personal services		
Physicians' services	No limit	Includes home, office, and hospital visits. Special limitations for mental illness.
Home health services	100 visits per year	--------------------------
Laboratory and X-ray	No limit	--------------------------
Outpatient physical therapy services	No limit	--------------------------
Podiatrist services	No limit	Excludes routine foot care.
Preventive services:		
Family planning services	By regulation	Includes services and supplies.
Prenatal and maternity care	By regulation	--------------------------
Well-child care	By regulation	For children under age 6.
Special services for children:		
Dental services (for children under age 13)	No limit	Routine services including examinations, fillings, extractions and replacements; excludes orthodontia.
Vision services (for children under age 13)	By regulation	Includes eye examinations and eyeglasses.
Hearing services (for children under age 13)	By regulation	Includes examinations and hearing aids.
Other services and supplies		
Prescription drugs	No limit	Includes full range of drugs of kinds available only by prescription, and any additional lifesaving drugs provided by regulation.
Blood and blood products	By regulation	--------------------------
Prosthetic devices	No limit	--------------------------
Medical equipment and supplies	No limit	--------------------------
Ambulance services	By regulation	Only when medically necessary.

Mental Illness

Under special limitations applying to mental illness, inpatient hospital care for mental illness is limited to 30 days in a year. Partial hospitalization (such as day or night care) is specifically covered, with 2 days of partial care substituted for each of the 30 available days of hospital care.

The total amount of benefit payments for outpatient mental illness services would be initially calculated by estimating the total charges for 30 visits to a private practitioner for the treatment of mental illness. (For illustration, 30 visits at say $30 a visit, or $900.)

However, the amount determined by this calculation represents the maximum amount of benefits payable annually for care in an approved comprehensive community care center. For care by a private practitioner or in other settings, the benefits payable would be one-half that maximum amount. (In the illustration above, $450.)

In either case, no limit is set on the actual number of visits in any setting (the reference in the law to 30 visits is given only to provide a basis for calculating the maximum dollar amount of benefits that would be payable).

Cost Sharing

Payment for all covered services, except drugs, would be subject to a common deductible of $150 annually per person (but with no further deductible after three members of a family have met the deductible for the year). Payment for drugs would be subject to a separate deductible of $50 annually per person (without regard to the regular $150 deductible). A separate deductible may be imposed on blood and blood products, by regulation. (There is no separate deductible for inpatient hospital care.)

Payment for all covered services, above the deductibles, would be subject to a coinsurance rate of 25 percent.

The maximum amount of cost sharing (deductibles and coinsurance) would be limited to $1,050 in a year for an individual and $1,500 for a family. Above that amount (referred to as the maximum family liability) all covered services would be provided with no further payment that year by the patient.

These deductibles would be in effect during the first 2 years of the program. Each year thereafter, the amount of the regular deductible would be raised in proportion to the increase in the average cost of the required benefit package. The drug deductible would also be increased so that it would continue to be one-third of the regular deductible.

Cost sharing paid during the year under the three plans of the proposal would be combined and counted toward the annual deductibles and the maximum family liability for cost sharing.

With unlimited hospital and other expensive services covered (including kidney dialysis and transplants) and with a limit on total cost sharing, the employee plan would protect most covered families against the high costs of catastrophic illnesses.

Additional Benefits

An employee health care plan may offer additional services supplementing the required services, reduce or remove any limitation on the amount of these benefits, and reduce or eliminate the cost sharing requirements. Any additional benefits provided would not be subject to the general requirements of the program (except the disclosure requirements, discussed later). The employee is not required to accept (or contribute toward) any additional benefits but could elect only the required benefits of the program.

Administration

The employer must inform his employees of the availability of his plan, its benefits, and its other provisions. He is forbidden by law to require the employee to forego participation in the plan as a condition of employment, to offer financial inducements to do so, or to offer an unapproved plan to his employees. Further, an employer may not discriminate in hiring, or in conditions of employment, because of the employee's health condition or that of his dependents (unless required by the nature of the job).

An employer could meet his obligations to provide an employee health care insurance plan by purchasing a health insurance policy insured by a carrier or providing a self-insured health plan. He could also provide the required health insurance by enrolling his entire employment group in the assisted health care insurance plan, as described later. (The bill also includes special provisions concerning prepaid plans, also described later.)

A recognized union or other bargaining agent could select, on behalf of the employees it represents, the options available on coverage (including choice of plan, decisions on additional coverage, and similar matters).

Any employed member of a family eligible under the coverage provisions of the law could take out a family policy covering the employee and eligible dependents.

Compliance and Approval

The Federal Government may require an employer to provide information concerning his compliance with the law, and could bring suit in Federal court to enforce the coverage and other provisions. An employee could also bring suit against his employer to obtain compliance.

The employee health plan must be approved by the State and the health insurance carriers and providers of service must be qualified under the program, as described later.

Financing

The employer must contribute at least 75 percent of the premium cost of the required health care insurance plan, but 65 percent for the first 3 years of the program. Employees must contribute the balance of the premium for the required insurance coverage.

If the employee elects to accept better coverage offered by his employer plan, he can be required to pay an additional premium. In any case, the contributions for better coverage and in fact the employer contributions (above that required by law) could be arranged or negotiated between employers and employees, as under present arrangements.

Premium rates would be set for an individual policy and for a family policy, with the individual rate being 40 percent of the family rate. No other variations in premium rates by family size or composition would be permitted. A family policy could include the husband and wife, their dependent unmarried children, and dependent parents living in the employee's residence (but not aged persons eligible under the Federal program).

Amount of Premium

The amount of the total premium would be negotiated between the insurance carrier and the employer. In general, the premium rate for large group insurance plans is based on the cost of benefits under the plan, a method of calculating called experience rating. However, experience rating is usually not used for small groups, but rather a variety of other rating methods are used. For firms with very few employees, perhaps just 1 or 2, group rates are often not available.

Under the proposal, all carriers who wish to sell approved coverage to employers with fewer than 50 employees must make coverage available to all such small employers in the State, and must charge them the same individual and family premium rates.

Under the proposal, that part of the premium rate applicable to benefits for persons who incur more than $10,000 annually in covered expenses for required benefits could not be included in the experience rating formula for a particular employer, but must be the same for all of a carrier's approved employee plans in the State (that is, averaged over that carrier's Statewide health insurance business).

The Department of Health, Education, and Welfare (DHEW) has estimated the national average premium rate for a required benefit plan at $600 annually for a family policy and $240 for an individual policy, at 1975 levels.

Federal Subsidy

If, as a result of the requirement to offer coverage, an employer's premium contributions increase his payroll by more than 3 percent, the Federal Government would pay a subsidy covering part of the excess over the 3 percent. The subsidy would be available for the first 5 years of the program, as follows:

Year of program	Percent of excess covered by subsidy
First........................	75
Second.......................	60
Third........................	45
Fourth.......................	30
Fifth........................	15
Sixth........................	No subsidy

The availability of the subsidy and its amount would be based on an employer's Statewide payroll and premium costs.

ASSISTED HEALTH CARE INSURANCE PLAN

The assisted plan is designed to make health insurance coverage universally available to all persons not otherwise insured against the costs of health care. The plan would be administered by the States through private carriers and financed by premium contributions from covered persons, and from Federal and State general revenues. It would cover the same health services as the employee plan, but with cost sharing and premiums varied according to family income.

Coverage

All individuals and families would be eligible to enroll in the assisted plan except (1) workers eligible for an employee plan with income over specified levels--namely, $5,250 for an individual and $7,500 for a family--and (2) aged persons eligible under the Federal health care insurance program.

Also, as indicated, an employer could meet his obligations to provide coverage under an employee health care insurance plan by insuring his entire employment group under the assisted plan (but, at relatively high premium rates). A worker in such an employment group under the assisted plan could elect out of the group and enroll in the assisted plan on a personal basis, for himself and his family. As discussed later, the provisions for cost sharing, premiums, and continuation of coverage under the assisted plan differ for workers who are part of an employment group and those enrolling on a personal basis.

While the eligibility provisions are relatively broad, the desirability of electing the assisted plan (as opposed to obtaining coverage under another approved plan or under a private plan) depends on the premium, benefits, and cost sharing provisions of the plan, and on the employment, income, and health characteristics of the persons or groups involved. A discussion of the persons and groups eligible for coverage under the assisted plan who would be expected to elect the plan is given later, after further description of the provisions of the plan.

Continuation of Coverage

As under the employee plan, coverage for workers in employment groups enrolled in the plan could continue for 180 days after termination of employment, with the employer required to contribute toward the premiums for the first 90 days.

Benefits

The health services covered under the assisted plan would be the same as those under the employer plan, but the cost sharing would vary according to family income. For the assisted plan, a family is defined to include the husband and wife, dependent unmarried children, and dependent parents living in the same household (but excluding any aged persons eligible for the Federal program). Family income could include income from all sources, but will be defined by DHEW regulations.

For cost sharing purposes, individuals and families would be classified in five income classes. The highest income class (class 5) consists of individuals with annual incomes of $7,000 and over and families with $10,000 and over. The income limits for the other four classes are calculated as a percentage of the class 5 income (namely, under 100 percent, 75 percent, 50 percent, and 25 percent, respectively). However, all individuals and families in employment groups under the assisted plan would be included in class 5. The income class limits and cost sharing provisions are shown in table 2.

TABLE 2.--Assisted Health Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductibles		Coinsurance rate	Maximum family liability	
		Regular	Drug		Percent	Amount
Individuals						
1...............	0-under $1,750	0	0	10	6	0-under $105
2...............	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3...............	3,500-under 5,250	100	50	20	12	420-under 630
4...............	5,250-under 7,000	150	50	25	15	788-under 1,050
5...............	7,000 and over	150	50	25	---	$1,050
Families						
1...............	0-under $2,500	0	0	10	6	0-under $140
2...............	$2,500-under 5,000	$50	$25	15	9	$225-under 450
3...............	5,000-under 7,500	100	50	20	12	600-under 900
4...............	7,500-under 10,000	150	50	25	15	1,125-under 1,500
5...............	10,000 and over	150	50	25	---	$1,500

Cost Sharing Provisions

The cost sharing provisions for class 5 are the same as for the employee health care insurance plan. For class 4, they are also the same, except that the maximum family liability is limited to 15 percent of income.

For income classes 1, 2, and 3 all of the cost sharing requirements are reduced. The reduction in the deductibles is calculated as a percentage of the maximum deductibles (namely, for classes 1, 2, and 3, the regular deductible is 0, 33, and 67 percent, respectively, of the maximum deductible; for the drug deductible, the corresponding percentages are 0, 50, and 100 percent, respectively). The reduced coinsurance rates and maximum family liability rates (after which no cost sharing is required for any members of the family) are specified in the law (table 2).

The initial income classes would be applicable for the first 2 years of the program. Each year thereafter, the class 5 income limit (called the income class base) would be increased according to the rise during the year in average earnings as shown in social security earnings records, with proportionate increases made in the other income class limits.

The initial cost sharing provisions would also apply during the first 2 years of the program. Each year thereafter, the amount of the maximum deductibles would be increased to the same amounts applicable to the employee plan (rather than based on the assisted plan), and proportionate increases made in the deductibles for the lower income classes.

Cost sharing under all plans of the program would be combined to determine when the deductibles and maximum family liability limits are met.

Administration

The assisted plan would be administered by the States under regulations established by the DHEW. Each State would submit its State assisted health insurance plan (which would include the provisions concerning eligibility, premium amounts, cost sharing requirements, and related matters) to the DHEW which would approve qualified plans and designate the State agency responsible for its administration. The DHEW approval may later be withdrawn if a State plan no longer complies with the law, or is administered in a way which results in noncompliance. If a State plan is not approved or approval is withdrawn, Federal payments would be withheld for the plan, or for the parts of it not in compliance. Disapproval of plans is subject to hearings and review by Federal courts.

The State of residence of eligible persons would be determined under regulations of the DHEW which would be designed to assure that coverage is available for migrant farmworkers and others who frequently move from State to State.

The States would contract with private insurance carriers to act as their agents to administer the insurance provisions of the plan. The carriers would be reimbursed for their administrative costs, but would not underwrite the insurance. Debts resulting from the failure of enrollees to pay premiums or cost sharing would be considered debts to the State rather than to the carrier. The State must assure confidentiality of information held by carriers about persons enrolled with them.

As an alternative, the States could administer the entire program themselves, without carriers, if authorized by the Department.

Financing

The costs of the assisted insurance plan would be financed by premium payments from enrollees, with the balance shared by State and Federal Government general revenues.

In calculating premiums, a two-rate premium structure would be used, as for the employee plan, with the rate for individuals 40 percent of the family rate. The premium rates would be based on the average premium for employee health care insurance plans in the State (rather than on the costs of the assisted plan) with the maximum premium set at 150 percent of the employee-plan premium.

The premium rates for enrollees (not in employment groups) in the plan would be based on their income class, as shown below. The amount of the premiums shown here are based on estimated national averages for 1975, and there would of course be variations among the States.

Income class	Percent of average employee-plan premium	Amount of premium	
		Individual	Family
1....................	0	0	0
2....................	0	0	0
3....................	50	$120	$300
4....................	100	240	600
5....................	150	360	900

For employment groups brought under the assisted plan by the employer, the premium contributions would be the maximum contribution--that is, the rate for class 5. As for employee plans, the employer would be required to pay at least 65 percent, initially, and later 75 percent of the total premium. The employee would pay the balance.

Where an employee has elected the assisted plan in lieu of his employer's health care insurance plan, the employer concerned would contribute to the assisted plan the same premium required under his own plan. The employee would contribute according to his income class.

State Contributions

The amount of the State contribution to the plan in a year would be determined by a formula based on (1) the State's ability to pay as measured by State per capita income compared with national per capita income, (2) the amount of benefits paid for services under the State assisted plan, and (3) the level of State expenditures under Medicaid, in the year before the program becomes effective, for these types of health services covered by the new program. The formula is designed to result in the States paying about one-quarter of the total Federal-State cost of the program, with the proportions varying according to State per capita income. (For the first year of the program, before benefit data under the assisted plan are available, a special formula would be used.)

The State would not be permitted to impose any premium tax on premiums paid under the assisted plan.

Election of Coverage

Table 3 shows the distribution, by employment status, of persons and groups eligible to elect coverage in the assisted plan, and those actually expected to elect it. In this table, the term "employed" refers to workers who meet the requirements for coverage under an employee health care plan. The "not employed" group refers to all other persons, including part-time workers, the self-employed, the nonemployed, and others. The term "high health risk" indicates individuals or families in relatively poor health who could expect to pay the maximum cost sharing under various plans.

Employed persons eligible under an employee health care plan may find it advantageous to elect the assisted plan, rather than their employee plan, depending on their income level, because of the income-related premiums and cost sharing provisions of the assisted plan. If the workers or their family members are in poor health and expect to pay high cost sharing, the assisted plan becomes desirable even at higher income levels.

TABLE 3.--Assisted Health Care Plan: Individuals, families, and employment groups, eligible for coverage and expected to elect coverage, by income and risk groups

Group	Eligible for coverage	Expected to elect coverage	
		Average health risk	High health risk
Employed:			
Individuals........	Under $5,250	Under $3,500	Under $5,250
Families...........	Under 7,500	Under 5,000	Under 7,500
Not employed:			
Individuals........	All	Under 5,250	All
Families...........	All	Under 7,500	All
Employment groups....	All	None	All

For employment groups, the health status of the group is probably the most important factor, although the relatively high premium rates usually applicable to small groups would also be a consideration.

The nonemployed poor, many of whom are now under the Medicaid assistance program, would receive coverage under the assisted plan on a basis related to their family income.

For the other "not employed" such as the self-employed, disabled persons, and others not part of an employment group, coverage is now available usually only on an individual (nongroup) basis, at considerably higher premium costs than for groups. This factor, as well as income levels and health status, would influence their decision to elect the assisted plan or other coverage.

The data in table 5 on page 42, which shows the premiums, cost sharing, and maximum liabilities, by income class, for the three plans, may be useful in understanding further the considerations involved in decisions to elect coverage under the assisted plan.

FEDERAL HEALTH CARE INSURANCE PLAN

Like the present Medicare program, the Federal health care insurance plan would cover aged persons insured under social security and be financed mainly by a continuation of the present Medicare payroll taxes and premium payments paid by covered aged persons. The plan would provide the same health services as the other two plans and thus improve the benefits of the present Medicare program. The low-income aged would receive the advantages of reduced cost sharing and premium payments, with these additional costs financed by Federal and State general revenues. The plan would be administered in a manner similar to the present Medicare program.

Coverage

As indicated, like Medicare, the program would cover persons who are insured under the social security program. Under temporary transitional provisions, every citizen (or permanent alien resident) who has reached age 65 in the first year of the program would automatically be covered (blanketed in) under the plan. Also, in following years, eligibility would be extended to additional persons who have specified credits under social security, but not enough to meet the regular Medicare requirements. Under these provisions, a person would need 3 quarters of coverage for each year from the second year of the program up to the year he reaches age 65. (Social security credits acquired at any time would be counted.) The provision would "wash out" when its requirements became the same as the regular requirements for insured status under social security.[1]

All Federal, State, and local government employees would become subject to the payroll taxes of the program and get credits toward coverage under the Federal program. The transitional provisions, described here, would of course assist newly covered persons to become insured under the program.

Persons age 65 and over not insured under the Federal plan could enroll under the assisted health care plan and would pay the cost sharing and premiums applicable to the assisted plan. Disabled persons who were brought under Medicare by P.L. 92-603 (H.R. 1) would not be included under the Federal plan, but most of these would be covered by the assisted plan.

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[1] Under the regular requirements, a person needs 1 quarter of coverage for each year after 1950 (or if later, the year he attains age 21) up to the year he becomes entitled to benefits. A person who has 10 years (40 quarters) of coverage is fully insured for life.

Benefit Structure

As indicated, the plan for the aged would cover the same health services as the other plans. Each aged person would be treated as an individual (regardless of family status) for cost sharing purposes and would pay the same amounts of cost sharing--amounts generally less than those required for individuals with comparable income under the assisted and employee plans. However, the low-income aged (those in classes 1, 2, and 3) would have the advantages of reduced cost sharing. These cost sharing provisions are shown in table 4. As for other plans, cost sharing under all three plans would be combined for determining when deductibles and maximum liability are met.

Administration

The Federal plan would be administered by the DHEW in a manner similar to the present Medicare program under which the processing of claims is handled by private carriers under contract with the Department, and Medicare taxes are collected by the Internal Revenue Service.

For the Federal plan, determination of income would be tied administratively to the Supplementary Security Income (SSI) program established by P.L. 92-603 (H.R. 1).

Financing

The present Medicare hospital insurance tax levied on wages and self-employment income would be continued at the same tax rate and earnings base as scheduled under present law and, as indicated, would be extended to cover all Federal, State, and local governments and their employees.

Each aged person eligible for the program would be required to enroll as an individual and pay a premium. The premium rate, which would be the same for all persons, would be calculated as an amount equal to 15 percent of the average cost to the program for an aged person in class 4, estimated at about $90 at 1975 levels. However, the low-income aged, in income classes 1 and 2, would pay no premium.

General Revenues

Funds from Federal general revenues would be paid to cover the cost of benefits and related administrative expenses of persons who become eligible under the special transitionally insured provisions, described above. Also, Federal and State general revenues, shared according to the formula used for the assisted plan, would pay the additional costs resulting from the reduced cost sharing for the aged in income classes 1, 2, and 3, and reduced premiums for classes 1 and 2.

TABLE 4.--Federal Health Care Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductible		Coin-sur-ance rate	Maximum individual liability	
		Regular	Drug		Percent of income	Amount
Individuals						
1...............	0-under $1,750	0	0	10	6	0-under $105
2...............	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3...............	3,500-under 5,250	100	50	20	12	420-under 630
4...............	5,250 and over	100	50	20	---	$750

All funds would be deposited and paid from a new Federal health care benefits trust fund.

The premium and cost sharing provisions for each of the three plans are summarized in table 5.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The States would have responsibility under Federal rules or guidelines for administration of major parts of the program, including (1) the approval of employee and other related health plans, (2) certification and regulation of providers of service participating in the program, (3) determination of reimbursement rates for providers of service, (4) supervision of the reimbursement system, and (5) regulation of insurance carriers. Generally speaking, these provisions would apply to all three plans of the program.

The DHEW would review the State laws, regulations, and administration relating to these functions and certify States which are qualified under the law. The decision of the Department on certification would be subject to hearing and review by Federal courts. Unless a State is certified, none of the three plans of the proposed program would go into effect in the State (but the present Medicare program would continue there). Further, as indicated later, at the start of the new program, Federal funding for State Medicaid programs would end in all States for the health services covered under the proposed new program.

As one of the requirements for participation, States must permit individuals to bring suit in State courts to compel the State, carriers, employers, and providers to comply with the State laws and requirements.

Approval of Employee Plans

Carriers providing an employee plan are required to file the plan with the State, which must promptly determine if it is qualified. The requirement would apply to all types of employee plans, including carrier-insured and self-insured plans. The States' approval could later be withdrawn if a plan is changed and no longer meets the requirements, or is administered in a manner which results in noncompliance. The carriers and employers concerned would be promptly notified of the qualification status of their plan.

TABLE 5.--Administration Proposal: Premium rates and cost sharing requirements, by type of plan

Income class	Annual income	Amount of premium 1/	Cost sharing requirements (per person)			Maximum family liability 2/	
			Regular deductible	Drug deductible	Coinsurance rate	Percent	Amount
			Employee health care plan				
All individuals..........		$240	$150	$50	25	---	$1,050
All families.............		600	150	50	25	---	1,500
			Assisted health insurance plan				
Individuals							
1........................	0-under $1,750	0	0	0	10	6	0-under $105
2........................	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3........................	3,500-under 5,250	$120	100	50	20	12	420-under 630
4........................	5,250-under 7,000	240	150	50	25	15	788-under 1,050
5........................	7,000 and over	360	150	50	25	---	$1,050
Families							
1........................	0-under $2,500	0	0	0	10	6	0-under $150
2........................	$2,500-under 5,000	0	$50	$25	15	9	$225-under 450
3........................	5,000-under 7,500	$300	100	50	20	12	600-under 900
4........................	7,500-under 10,000	600	150	50	25	15	1,125-under 1,500
5........................	10,000 and over	900	150	50	25	---	$1,500
			Federal plan for the aged 2/				
Individuals							
1........................	0-under $1,750	0	0	0	10	6	0-under $105
2........................	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3........................	3,500-under 5,250	$90	100	50	20	12	420-under 630
4........................	5,250 and over	90	100	50	20	---	$750

1/ Total estimated national average premium at 1975 levels. For employee plan and, in some cases, for assisted plan, the employee and employer would share payment of the premium.

2/ Under Federal plan for the aged, eligible persons would be treated as individuals, regardless of family status.

Certification and Regulation for Providers of Service

Standards for Participation

The standards for participation by providers of service in the new program are similar to those of the present Medicare program. In addition, provision is made for expanded participation of optometrists and dentists who must be legally authorized to practice in their State. Chiropractors are excluded as providers. (Medicare standards are shown on page 225.)

The law provides for participation of physicians' extenders--including physicians' assistants, nurse practitioners, and similar personnel--in the program, and establishes the following standards for these personnel. The law also indicates additional standards could be set by regulation:

(1) They must perform services under the supervision and control of a physician, or act as his agent, and these services must be related to the supervising physician's type of practice.

(2) They must complete a training program, or pass a certification examination of an appropriate organization, or meet certain proficiency requirements--in all cases, as approved under DHEW regulations.

(3) The charges for their services must be included in the bills of the supervising physician or employing organization.

(4) The performance of the services must be legal under State law.

Disclosure for Providers

Under regulations to be established by the DHEW, providers of service must make available to persons seeking care information on (1) charges for common services, (2) hours of operation and other information about access to services, and (3) any license, accreditation, or certification held by the provider.

Control of Capital Expenditures

The bill incorporates the provisions of P.L. 92-603 (H.R. 1) which requires approval by the State planning agency of substantial capital expenditures in health care facilities. The present law, applicable to Medicare, Medicaid, and certain other federally aided programs, imposes penalties by excluding reimbursement for depreciation and interest from the payment for services provided by the disapproved capital improvement. The bill would greatly strengthen the penalty by eliminating the entire payment for the services provided by the disapproved capital improvement. This new provision would apply to all plans of the proposed program as well as programs covered by present law.

Professional Standards Review Organization (PSRO)

The proposal incorporates the PSRO provisions of P.L. 92-603 (H.R. 1) for review of the necessity and quality of services under Medicare, Medicaid, and other programs, and extends these PSRO provisions to services under all three plans of the new program.

It also amends the PSRO law to require mandatory review of outpatient services. Under present law, review is only required for inpatient services and is optional for outpatient care. The new requirement would also apply to programs now subject to PSRO.[2]

Reimbursement of Providers of Service

The States would establish rates of reimbursement for covered services for the three plans of the program, in accordance with procedures and criteria established by DHEW. These rates would be made publicly available.

Reimbursement System

Persons enrolled in all plans would be issued a health card, to identify them as enrolled under the program, and a health card account would be established for each enrollee. These accounts would be similar to accounts maintained by credit organizations and would serve as the basis for reimbursement of providers of service.

The account would serve as the vehicle for payments from carriers and other sources for reimbursement to providers of service. Providers who are participating in the program would be required to elect as either a full participating or an associate participating provider. All hospitals, skilled nursing facilities, and home health agencies must elect as full participating. The States would certify providers as qualified full or associate providers and make this information publicly available. Individuals could challenge the State certification in State courts.

2/ Unlike the other provisions discussed under this section on administration and regulation of the program, the PSRO provisions would not be a primary responsibility of the State.

Full participating providers must accept the State-established rate for a service as their full charge for patients under all plans of the program. The health card account would pay them the full established rate for their service, including the cost sharing due from the patient. Associate providers must also accept payment on this basis for patients under the assisted plan and the Federal plan for the aged. The account would collect the cost sharing from the patient who could pay on credit over a period and at interest rates indicated by DHEW regulations.

Associate providers could refuse to accept the established rate as full payment for employee-plan patients, and could charge the patient an additional fee or amount above that rate. In this case, the health card account would pay them only the covered (insured) part of the charges, at the established rate, and the provider would need to collect both the cost sharing and the additional fee directly from the patient.

However, an exception is made for pharmacies and other drug providers who, though certified as associate providers, would receive the established rate including the cost sharing from the health card account, and could collect additional charges from the patient. This special provision would apply to persons under all three programs. It would of course be expected that patients would tend to purchase from pharmacies which do not impose any additional charges.

Anti-Duplication

The bill permits coverage only under one approved plan and provides that, if a person is enrolled under more than one plan, only one of the plans would pay for any service, as determined by DHEW regulations.

Regulation of Insurers

The law would permit various types of organizations, including voluntary associations, corporations, and partnerships to qualify as approved health insurance carriers. The organization could be one which pays for or provides health services under group insurance policies, hospital or medical service agreements, or membership or subscription contracts.

Employers who self-insure on a qualified basis, and pay for or provide health services directly for their employees, could also participate as approved carriers.

The States would be required to regulate and enforce the following requirements of the Federal law for carriers of all types, but could impose more stringent requirements if they wished:

(1) The carriers would be required to file with the State a statement of rates or rating formulas (referred to as "file and use" procedures) for each approved employee plan. The statement must include sufficient information to permit the State to determine if the rates are reasonable in relation to the benefits provided and the State could disapprove or suspend rates considered unreasonable.

(2) An annual audit of each carrier must be conducted by a certified public accountant (CPA) and the reports made public.

(3) Upon request, the carrier must disclose to persons to whom a plan is offered, the plan's (a) benefits and exclusions, (b) premium rates, and (c) the percentage of the premiums expected to be paid in benefits.

The States must also determine the adequacy of the carriers financial condition to meet their obligations and, if a carrier is found to be financially insolvent or impaired, must assure that the carriers obligations will be met--by being paid in full, guaranteed, assumed or reinsured. This requirement could be implemented under an insolvency or guarantee fund or other means established or regulated by the State.

Reporting and Evaluation of the Program

The DHEW would establish requirements for reporting of information necessary to enable it to monitor and evaluate the program, as follows:

(1) Employee health care plans are required to maintain uniform statistical methods and procedures and to report information requested by the Department.

(2) States are required to report information requested by the Department concerning the State assisted plan.

(3) States are required to report to the Department on their activities concerning approval of health care plans, establishment of reimbursement rates, certification of providers, and regulation of providers of service and insurance carriers.

Each year the Department would prepare a report to the President, for transmittal to Congress, which would include a summary of its activities concerning the program, appraisal of the adequacy of the program and, if any, recommendations for additional legislation.

Relationship to Other Government Programs

Federal funds for State Medicaid programs would be limited to the following services: (1) intermediate care facilities, (2) skilled nursing facilities for persons age 21 and over, (3) home health services, (4) care in mental institutions for persons under age 21 and over age 65, and (5) medical or remedial care for persons in a medical institution, or needed to reduce the need for such institutionalization. In all cases, covered health services, cost sharing, or premiums under the new program could not be included for Federal matching funds.

The new program would not pay for services covered under workmen's compensation laws. The health insurance program for Federal employees and retirees and the health programs of the Veterans Administration, the Indian Health Services, and other Federal programs for special groups would continue to operate. The Administration has announced its intention of proposing legislation concerning the relationship of these special Federal programs with the proposed new program.

PREPAID HEALTH PLANS

The proposal establishes requirements for participation under the program of prepaid health plans and includes special provisions designed to facilitate and encourage enrollment in these plans.

Employee Health Care Plans

All employers required to offer their employees a health care plan must offer a choice of (1) a health care insurance plan, as described earlier in the discussion of employee plans, (2) a group practice prepaid plan, or (3) an individual practice prepaid plan. The need to offer prepaid plans may be waived if they are not available in the community, as decided by DHEW regulations.

To qualify as an employee plan, the prepaid plan must be approved by the State (like other employee plans) and must meet the general requirements for employee plans including continuation of coverage, anti-duplication provisions, a two-rate premium structure, and reporting requirements to DHEW.

For an employee who elects a prepaid plan, the employer is required to contribute at least 75 percent (initially 65 percent) of the premium cost of the required basic health insurance plan (that is, the same amount he contributes toward basic benefits under his employee insurance plan). If the prepaid plan charges a higher premium, the employee can be required to pay the additional amount.

Assisted Plan and Federal Plan for the Aged

Persons eligible under the assisted plan would also have the option of electing coverage under an approved prepaid health plan as an alternative to coverage under the regular State assisted health care insurance plan. If so, the State would pay the prepaid plan a capitation amount equal to the average cost of coverage under the regular State assisted health insurance plan. Any additional premiums charged by the prepaid plan would be paid by the enrollee.

Similarly, persons eligible under the Federal health care insurance plan could enroll in a prepaid plan, in which case the Federal program would pay the prepaid plan a capitation amount equal to the average cost of the Federal program, and the enrollee would pay any additional premium required by the prepaid plan.

Requirements for Prepaid Plans

To be approved under the program, prepaid health plans are required to meet the general requirements of the program and certain special requirements. As a participating provider of service, it must meet the certification standards and regulations applying to providers, described earlier, and, if it acts as its own carrier, any regulations established for them as insurance carriers. In addition, group practice plans must meet the following requirements of the law:

(1) They must provide, or arrange for, all the required health services under the program, but may vary or remove the cost sharing and limitations on these benefits.

(2) The plans must be reimbursed by means of a predetermined (capitation) rate for all their services, except that they may impose copayments as authorized by DHEW regulations.

(3) They must provide physicians' services through physicians who are employees or partners of the plan, or through arrangements with physicians' groups engaged in the coordinated practice of their profession.

(4) The plans must be organized in a manner so that (a) they bear responsibility for the efficient and effective use of health resources, (b) the components affiliated with the plans share that responsibility, and (c) they provide a clear focal point of responsibility.

An individual practice plan must meet the same requirements as a group plan except that physicians' services would be provided through arrangements with physicians practicing on an individual practice basis (rather than as indicated in item 3 above).

SUMMARY OF PROPOSED COMPREHENSIVE HEALTH INSURANCE ACT OF 1974 (H.R. 4747, REFERRED TO WAYS AND MEANS COMMITTEE)

Title I of the bill would replace the present title XVIII of the Social Security Act with a new title XVIII entitled "Health Care Benefits" and composed of six parts.

Part A would establish an employee health care benefits program. Section 1801 would require every employer to offer to each of his permanent full time employees under the age of 65, defined as employees who worked 25 hours per week for ten weeks, or 350 hours, in the preceding thirteen weeks, the opportunity to obtain, for himself and the members of his family under the age of 65, coverage under (1) an approved employee or assisted health care insurance plan, (2) an approved group practice prepaid health care plan, or (3) an approved individual practice prepaid health care plan, at the option of the employee. The Secretary would have authority to specify the circumstances in which an employer did not have to offer coverage under a prepaid health care plan because such a plan was not available in the area. An employer required to offer coverage under a plan to one or more full time permanent employees would be required to also offer coverage to all other full time employees, defined as employees who worked 25 hours in the preceding week.

A recognized bargaining agent could exercise on behalf of the employees it represented, the options available to those employees.

Section 1802 would require an employer to contribute toward the cost of any coverage elected by a permanent full time employee 75 percent of the cost of coverage under the employee or assisted health care insurance plan offered by the employer. This contribution would be required so long as the employee was a permanent full time employee and for 90 days after termination of that status.

Section 1803 would require an employer to provide his employees with information concerning the health care plans available to them.

Section 1804 would prohibit an employer from offering an employee to whom he must offer coverage under section 1801 coverage under any arrangement for the provision or financing of health care which was not an approved health care plan, except that an employer would be permitted to offer (1) coverage under a special employee health care program, and (2) coverage which supplemented an approved plan for employees covered under an approved plan. Acceptance of supplemental coverage could not be a condition to obtaining coverage under an approved plan.

Section 1805 would prohibit an employer from discriminating in his employment practices on the basis of health status, except when directly related to the capacity of an individual to perform his duties as an employee.

Section 1806 would exempt the United States, foreign governments and international organizations from the obligations imposed upon employers by part A. State and local governments would not be exempt.

The provisions of part A would apply only to employment performed in States certified by the Secretary under section 1861.

Part B of the new title XVIII would establish a program of grants to States for health care benefits programs. Section 1821 would authorize the appropriation of the sums necessary for such grants.

Section 1822 would contain the requirements for a State plan for the provision of health care benefits and would require the Secretary to approve any plan which met those requirements and was submitted by a State certified by the Secretary under section 1861.

To be approved a State plan would have to provide that benefits would be available to (1) members of any family residing in the State who were not entitled to benefits under part C, were not covered under a health care plan pursuant to part A, and had an aggregate annual income of less than 52.5 percent of the income class base in the case of one member families, or 75 percent of the base in the case of more than one member families, (2) members of any family residing in the State who were not entitled to benefits under part C and were not eligible for coverage under a health care plan pursuant to part A, and (3) employers for the purpose of offering the benefits, pursuant to part A, to employees whose place of employment was within the State. The income class base would be $10,000 for the first two years of the program and would be adjusted each year thereafter on the basis of increases and decreases in the taxable wages reported to the Secretary under the OASDI program.

The plan would have to provide that the benefits under the plan would be the opportunity to obtain coverage under an assisted health care insurance plan, or, at the option of the family or employee, to have the State contribute the cost to it of coverage under that plan to an approved prepaid health care plan.

The plan would also have to provide that eligibility for benefits under the plan would be determined by a public agency designated by the Secretary; that coverage under an assisted health care insurance plan would be offered through arrangements with carriers, unless the Secretary authorizes the State to offer coverage directly; and that carriers would be reimbursed on the basis of benefit payments plus administrative expenses. It would also have to provide that if any member of a family receiving benefits under the plan was an employee eligible for coverage under part A, the employer of that employee would be required to pay the State the amount the employer would have been required to contribute had the employee obtained coverage under part A. Finally, the plan would have to provide for compliance with a number of administrative and technical requirements, including requirements related to the control of access to information obtained in connection with administration of the plan.

Section 1823 would contain the formula for determining the State and federal contributions toward the cost of operating an approved State plan. The State share in the first year of a plan would be the amount of the State's contribution under the Medicaid program during fiscal year 1975 for services other than skilled nursing facility, home health, intermediate care facility, mental hospital, and dental services, plus ten percent of the difference between the expenditures under the plan and the expenditures under the Medicaid plan during fiscal year 1975 for services other than skilled nursing facility, home health, intermediate care facility, mental hospital, and dental services, adjusted on basis of the per capita income of the State. In subsequent years the State share would be the State contribution during the first year plus twenty five percent of the difference between the expenditures under the plan and the expenditures under the plan during the first year, adjusted on the basis of the per capita income of the State.

Section 1824 would authorize the Secretary to withhold federal payments to a State if he determined that the State's plan did not meet the requirements of section 1822 or that there was a substantial failure to comply with those requirements in the administration of the plan.

Section 1825 would establish the requirements for an assisted health care insurance plan offered by a State under its health care benefits plan. An assisted health care plan would cover the same services, subject to the same limitations, as employee health care insurance plans. It would also meet all of the other applicable requirements for those plans, except that it would have a special income related premium and cost sharing structure, and a somewhat different HealthCard system.

The annual premium for coverage under an assisted health care insurance plan would be determined on the basis of the estimated average annual premium for coverage, in the State, under an approved employee health care insurance plan, of an employee and the members of his family under the age of 65. An employee covered under the plan through his employer would pay 150 percent of this amount if he had a family and 60 percent of this amount if he did not. A family covered separately under the plan would pay a percentage of this amount depending on its size and income class. The percentages for one member family groups would be as follows:

Class:	*Percent*
I	0
II	0
III	20
IV	40
V	60

The percentages for more than one member family groups would be as follows:

Class:	*Percent*
I	0
II	0
III	50
IV	100
V	150

An assisted health care plan would impose a per individual per year deductible for services other than outpatient drugs and blood and blood products determined on the basis of the deductible base, which would be $150 for the first two years of the program, and would be adjusted each year thereafter on the basis of increases and decreases in the acturial value of coverage under an employee health care insurance plan. For an employee covered under the plan through his employer the deductible would be equal to the deductible base. For a family covered under the plan the deductible would be equal to a percentage of the deductible base determined on the basis of its income class. The percentages would be as follows:

Class:	Percent
I	0
II	33⅓
III	66⅔
IV	100
V	100

No further deductible would be imposed in any year after three members of a family group or employee and his family satisfied the deductible requirement for that year.

There would be a separate per individual per year deductible for outpatient drugs. For an employee covered under the plan through his employer the deductible would be equal to one-third the deductible base. For a family covered under the plan the deductible would be equal to a percentage of the deductible base determined on the basis of its income class. The percentages would be as follows:

Class:	Percent
I	0
II	16⅔
III	33⅓
IV	33⅓
V	33⅓

The Secretary would be authorized to establish a deductible for blood and blood products.

The plan would impose a coinsurance requirement on expenses in excess of any applicable deductibles. The coinsurance rate for an employee covered under the plan through his employer would be 25 percent. For a family covered under the plan the coinsurance rate would be based on its income class. The rates would be as follows:

Class:	Percent
I	10
II	15
III	20
IV	25
V	25

The plan would impose no further cost sharing in any year after the total of the deductibles and coinsurance amounts imposed under the plan equaled a prescribed amount. For employees covered under the plan through their employers and families in income class V, this amount would be 10.5 percent, in the case of one member family groups and employees without family members under the age of 65, or 15 percent, in the case of more than one member families and employees with one or more family members unedr the age of 65, of the income class base. The income class base would be $10,000 for the first two years of the program and would be adjusted each year thereafter on the basis of increases and decreases in the taxable wages reported to the Secretary under the OASDI program. For other families the maximum annual cost sharing under the plan would be a percentage of family income determined on the basis of income class: The percentages would be as follows:

Class:	Percent
I	6
II	9
III	12
IV	15

The income class of a family would be determined by applying the family's income to an income class structure that is based upon the income class base, which would be $10,000 for the first two years of the program and which would be adjusted each year thereafter on the basis of increases and decreases in the taxable wages reported to the Secretary under the OASDI program. The upper limits of the classes would depend on family size and would be expressed as percentages of the income class base. The percentages from one member family groups would be as follows:

Class:	*Percent*
I	17.5
II	35
III	52.5
IV	70
V	---

The percentages for more than one member family groups would be as follows:

Class:	*Percent*
I	25
II	50
III	75
IV	100
V	--

An assisted health care insurance plan would include a HealthCard system under which covered individuals could charge the cost of covered services. The plan would pay providers on the basis of those charges at the applicable reimbursement rates, without reduction on account of any applicable deductible or coinsurance unless the charge account was in default. Deductible and coinsurance amounts paid by the plan would be billed to the covered individual, and an account would be in default only if the payment of such bills was 90 days in arrears.

Part C of new title XVIII would establish a program of federal health care benefits for the aged. Section 1831 would provide that any individual residing in a State certified under section 1861 who is 65 years of age or older, and who is entitled to benefits under section 202 of the Social Security Act, or would be entitled to such benefits if all employment subject to the hospital insurance tax were covered employment for the purpose of determining entitlement to such benefits, shall be entitled to federal health care benefits. The benefits would be the opportunity to obtain coverage under the federal health care insurance plan, or, at the option of the individual, to have the program contribute the cost to it of coverage under that plan to an approved prepaid health care plan.

Section 1832 would establish the requirements for the federal health care insurance plan. The plan would cover the same services, subject to the same limitations, as employee health care insurance plans. It would also meet all of the other applicable requirements for those plans, except that it would have a special premium and cost sharing structure, and its HealthCard system would be identical to the HealthCard system of assisted health care insurance plans.

The annual premium for coverage under the federal health care insurance plan would be 15 percent of the estimated average cost of coverage under the plan of an individual in income class IV, except that no premium would be charged in the case of individuals in income classes I and II.

The cost sharing requirements imposed by the plan would be identical to those imposed on one member family groups by assisted health care insurance plans except that in no case would the annual deductible for services other than outpatient drugs and blood and blood products exceed two thirds of the deductible base, in no case would the deductible for outpatient drugs exceed one-third of the deductible base, in no case would the coinsurance rate exceed 20 percent, and in no case would the maximum annual cost sharing exceed 7.5 percent of the income class base.

The income class of an individual would be determined on the basis of the same standards as those used in determining the income class of one member family groups under assisted health care insurance plans.

Section 1833 would authorize the use of carriers in the administration of the federal health care insurance plan.

Section 1834 would direct the Secretary to make all payments under part C out of the Federal Health Care Benefits Trust Fund.

Section 1835 would establish the Federal Health Care Benefits Trust Fund and permanently appropriate to it an amount equal to the revenue received by the federal government from the hospital insurance tax on employment and self-employment in States certified under section 1861.

Section 1836 would authorize the appropriation to the Trust Fund, from the general revenues, the amounts necessary to place the Trust Fund in the same position it would have been in if all individuals receiving federal health care benefits were in income class IV.

Part D of the new title XVIII would deal with the requirements for approval of health care plans and special employee health care programs and for certification of providers.

Section 1841 would establish the requirements for approval of an employee health care insurance plan. In general the plan would cover inpatient hospital services, physicians' services, medical and other health services, home health services, post-hospital extended care services, outpatient drugs and biologicals, and routine dental services, developmental vision care services, eye examinations, eye glasses, hearing examinations, and hearing aids for individuals under the age of 13.

This coverage would be subject to several limitations. Services unrelated to congenital defect, illness, injury, or the improvement of the functioning of a malformed body member would not be covered except for family planning and maternity services, the special services for individuals under the age of 13, and well child care for individuals under the age of six. Services provided outside the United States would not be covered, except for emergency inpatient hospital and physicians' services. Services for which there is no obligation to pay, or for which payment is made under a workmen's compensation would not be covered. Personal comfort items, custodial care, routine foot care, and most cosmetic surgery would also be excluded. Orthopedic shoes and treatment of weak or flat feet would be covered only for individuals under the age of six. Kidney dialysis and transplantation services would be covered only when provided in facilities which met requirements prescribed by the Secretary. Extended care services would be limited to 100 days per year, and home health services to 100 visits per year. Inpatient hospitalization for mental illness would be limited to thirty days per year, with partial hospitalization counting as one-half a day. Outpatient services for the treatment of mental illness would be limited to the cost of 30 visits to a private practitioner, only one-half of which would be available for services not provided in a comprehensive community care center. The Secretary would be authorized to establish limits on routine eye and vision examinations, eye glasses, hearing examinations, hearing aids, family planning and prenatal and post natal services, and well child care.

The plan would impose a per individual per year deductible for services other than outpatient drugs and blood and blood products equal to the deductible base, except that no further deductible would be imposed in any year after three members of a family met the deductible requirement for that year. There would be a separate per individual per year deductible for outpatient drugs equal to one-third of the deductible base, and the Secretary would be authorized to establish a deductible for blood and blood products. The deductible base would be $150 during the first two years of the program and would be adjusted each year thereafter on the basis of increases and decreases in the actuarial value of coverage under an employee health care insurance plan.

The plan would impose a 25 percent coinsurance requirement on expenses in excess of any applicable deductible.

No further deductible or coinsurance requirement would be imposed in any year after the total of the deductibles and coinsurance imposed under the plan equaled 10.5 percent of the income class base, in the case of employees without family members under the age of 65, or 15 percent of that base, in the case of employees with such family members. The income class base would be $10,000 during the first two years of the program, and would be adjusted each year thereafter on the basis of increases and decreases in the average of the taxable wages reported to the Secretary under title II of the Social Security Act.

The plan would provide that a permanent full time employee covered under the plan would continue to be covered for 180 days after he ceased to be a permanent full time employee.

The plan would provide that coverage would not be terminated for failure to pay the premiums unless payment was 90 days in arrears and notice of termination had been given.

The plan would include a HealthCard system under which covered individuals would charge the cost of the covered services. The plan would pay providers on the basis of those charges at the applicable reimbursement rates. In the case of full participating providers and charges for outpatient drugs and biologicals, payment would not be reduced on account of any applicable deductible or coinsurance, unless the charge account was in default. Deductible and coinsurance amounts paid by the plan would be billed to the covered individual, and an account would be in default only if the payment of such bills was 90 days in arrears.

Payment for services would be made by the plan in accordance with the reimbursement rates and standards established under section 1861, and, except for emergency services, payment would be made only to participating providers. Payment would also be subject to the PSRO system established by part B of title XI of the Social Security Act and the capital expenditure review program established by section 1122 of that Act.

No individual would be covered under more than one health care plan, and in the event of duplicate coverage only one plan would pay for covered services.

The portion of the premium for coverage under the plan that represented the cost of providing coverage in excess of $10,000 per individual per year would be the same for all coverage under all employee health care insurance plans of the plan's carrier.

The premium for coverage under the plan would be the same for all employees of any single employer, except that the rate for employees without family members under the age of 65 would be 40 percent of the rate for employees with such family members.

Section 1842 would establish the requirements for approval of a group practice prepaid health care plan. The plan would provide for the provision of at least the services covered under an employee health care insurance plan. It would be compensated for the provision of those services on a predetermined periodic rate basis, except for such copayments as the Secretary authorized.

The plan would provide physicians' services through physicians who were employees or partners, or through arrangements with groups of physicians engaged in the coordinated practice of their profession. It would also meet other requirements concerning its organization structure and financial arrangements prescribed by the Secretary.

The plan would meet the same requirements as an employee health care insurance plan with respect to extended coverage for former permanent full time employees, coverage in the event of failure to pay premiums, the applicability of the PSRO system and the capital expenditure review program to services provided under the plan, the prohibition against duplicate coverage, and uniformity of premium rates.

Section 1843 would establish the requirements for approval of an individual practice prepaid health care plan. The plan would be identical to a group practice prepaid plan, except that physicians' services would be provided through arrangements with physicians engaged in the practice of their profession on an individual practice basis.

Section 1844 would establish the requirements for approval of an employee special health care program. The program would provide, or provide for payment for, at least the services covered under an employee health care insurance plan. So much of the program as provided services would have to meet the requirements for a prepaid health care plan. So much of the program as provided for the payment for services would have to meet the requirements for an employee health care insurance plan.

Section 1845 would establish the requirements for the certification of providers. To be certified, a provider would have to be eligible to provide some service covered under a health care insurance plan. In addition the provider would have to agree to accept charges against Health-Card accounts as the sole means of obtaining payment for so much of the charges for covered services as were payable by the plan. To be certified as a full participating provider, a provider would, in addition, have to agree to accept the payments made by the plan on the basis of those charges as payment in full. To be certified as an associate participating provider, a provider would have to agree to accept payments made by a plan as payment in full only with respect to covered services other than outpatient drugs, and only with respect to individuals covered under an assisted health care insurance plan or the federal health care insurance plan.

Hospitals, skilled nursing facilities, and home health agencies would not be eligible for certification as associate participating providers.

Part E of the new title XVIII would provide for the certification of States which meet a series of requirements related to administration of the health care benefits program in that State. Section 1861 directs the Secretary to certify any State which, by statute or regulation—

(1) provides for the review and approval of health care plans and special employee health care programs available within the State,

(2) establishes the reimbursement rates and standards applicable to payments for services by health care insurance plans, in accordance with regulations prescribed by the Secretary,

(3) provides for the certification of providers in the State,

(4) provides for administration of the Health Card system in the State,

(5) requires any carrier which offers an approved employee health care plan to an employer in the State with less than 50 employees to offer the plan to all such employers at the same rates,

(6) has in effect an agreeemnt with the Secretary under section 1122 of the Social Security Act,

(7) provides for the review of the rates for coverage under approved health care plans in the State,

(8) requires an annual audit of all carriers of approved health care plans,

(9) requires the disclosure of certain information by any carrier which offers, in the State, any plan for the provision or financing of health care,

(10) requires certified providers to make available to individuals covered under health care insurance plans information concerning matters such as the provider's charges and hours of operation,

(11) provides for protecting individuals covered under approved health care plans in the event that a carrier or self-insured employer cannot meet its financial obligations,

(12) provides for the coordination of employee and assisted health care insurance plans with other insurance which finances health care, and

(13) provides an opportunity for an aggrieved person to bring suit to compel compliance with the statutes and regulations required by items (1) through (12).

Section 1862 authorizes the Secretary to require employers to furnish information concerning compliance with the requirements of part A.

Section 1863 authorizes agreements with other Federal agencies concerning performance of the Secretary's function under title XVIII.

Section 1864 provides for judicial review of various decisions of the Secretary.

Section 1865 would establish civil remedies and criminal sanctions for failure to comply with the requirements of part A.

Part F of the new title XVIII would consist of two miscellaneous provisions. Section 1881 would define various terms used in title XVIII, and section 1882 would provide for an annual report to Congress on the activities carried out under that title.

Section 102 of the bill would provide that the amendment to the Social Security Act made by section 101 shall be effective January 1, 1976, or, if later the first day of the first calendar year commencing at least 18 months after enactment of the Act.

Section 103 would provide special federal subsidies for certain employers during the first five years that the requirements of part A of title XVIII were applicable to them. If, during any of the first five years in which the requirements of part A of the new title XVIII applied to an employer, the difference between the cost to the employer of meeting those requirements and the cost to the employer of providing health care benefits for his employees in the year before the requirements applied to him exceeded three percent of the total cash wages paid by the employer, the Secretary would pay the employer 75 percent of that excess in the first year that part A applied to him, 60 percent in the second year, 45 percent in the third year, 30 percent in the fourth year, and 15 percent in the fifth year.

Section 104 would provide that the employer contribution rate under part A of the new title XVIII shall be 65 percent, rather than 75 percent, for three years beginning with the date that the State in which the employment is performed is certified under section 1861 of the new title XVIII.

Section 105 would provide for transitional eligibility for federal health care benefits under part C of the new title XVIII. Any individual who became 65 before or during the year in which the new title XVIII became effective would be eligible for federal health care benefits. Individuals who became 65 in subsequent years would have to have three quarters of coverage, including coverage from employment subject only to the hospital insurance tax, for each year that had elapsed since the new title XVIII became effective in order to be eligible for federal health care benefits. The cost of providing federal health care benefits to individuals eligible under this transitional provision would be borne by the general revenues.

Title II of the bill would amend the Medicaid program to limit the services with respect to which federal financial participation was available to—

(1) skilled nursing facility services, other than in an institution for tuberculosis or mental diseases, for individuals 21 years of age or older,

(2) home health care services,

(3) intermediate care facility services, other than services in an institution for tuberculosis or mental diseases,

(4) for individuals over 65 years of age, inpatient hospital services in an institution for mental diseases, and skilled nursing and intermediate care facility services in an institution for tuberculosis or mental diseases,

(5) inpatient psychiatric hospital services for individuals under 21, and

(6) other medical care specified by the Secretary provided to an individual in an institution or intended to reduce the need for institutionalization.

Federal matching would not be available for payments with respect to any services covered under an assisted health care insurance plan.

Title II would also provide that States which are not certified under section 1861 of the new title XVIII would not be eligible to participate in the Medicaid program.

Title III of the bill contains minor, technical and conforming amendments.

Section 301 contains conforming amendments to the Professional Standards Review Program. It would, in addition, amend that program to make review by local PSRO's of outpatient as well as inpatient services mandatory.

Section 302 contains conforming amendments to the capital expenditure review program. It would also amend that program to provide that no payment shall be made for services provided in a facility disapproved under the program.

Section 303 contains miscellaneous conforming amendments to the Social Security Act.

Section 304 would amend section 322(a) of the Public Health Service Act to permit the Secretary to impose charges for the provision of health services to merchant seamen and similar primary beneficiaries of the Public Health Service.

Section 305 contains conforming amendments to the Railroad Retirement Act of 1937.

Section 306 would amend section 3121 of the Internal Revenue Code to make federal, State, and local employment subject to the federal hospital insurance tax.

Mr. Rogers. Thank you, Dr. Carter, for an excellent statement. Your stress on the preventive care aspects, which certainly should be stressed, was particularly interesting.

Mr. Florio.

Mr. Florio. Yes, Mr. Chairman.

Doctor, with regard to the plan you referred to as EHIP, what would happen if a worker, for economic constraints, or whatever reasons, had decided not to take part, where does he get covered, or does he get covered?

Mr. Carter. All right, of course enrolling in the employee plan is voluntary, but if the worker's decision is because of low income, this is where he gets assistance to buy his insurance.

Mr. Florio. AHIP?

Mr. Carter. Yes, sir.

Mr. Florio. The second provision?

Mr. Carter. Yes.

Mr. Florio. Even though he was eligible for EHIP he is still going to be eligible for AHIP if he decides he doesn't want to take advantage of the EHIP provision?

Mr. Carter. If he is a low-income individual; that is, if his income is in the range of $2,500.

Mr. Florio. But he is employed?

Mr. Carter. Yes.

Mr. Florio. And he is employed in a facility where this is available to him?

Mr. Carter. Yes, sir.

Mr. Florio. He has discretion to say yes or no, and if he says no and he is a low-income person——

Mr. Carter. He is eligible for the second group.

Mr. Florio. The second group, is that not essentially medicaid?

Mr. Carter. No, it is not. The cut-off point for AHIP eligibility is below $7,500 income for families and $5,250 for individuals who would otherwise be eligible for EHIP. We need to distinguish between individual and family coverage.

Mr. Florio. Under $7,500?

Mr. Carter. Yes, sir.

Mr. Florio. A person makes $6,000, works, decides not to partake in the employee plan, he can then be under AHIP?

Mr. Carter. Yes, sir.

Mr. Florio. If a person making $8,000—are we talking about limits with regard to family members as well, $8,000 absolute member, or——

Mr. Carter. I think this would probably include a family of four, a man, wife, and two children.

Mr. Florio. So the person who made $9,000 and didn't feel he could economically afford to enroll and didn't enroll would not be eligible for the AHIP?

Mr. Carter. That is right.

Mr. Florio. The AHIP is essentially medicaid, isn't it?

Mr. Carter. No; AHIP is not medicaid at all. Medicaid is not a uniform system, in the sense that some States provide comprehensive benefits, while other States provide very minimal benefits. Under H.R. 4747, all groups would be eligible for the same set of comprehensive benefits. Also, in this bill, under the AHIP program would include some people who are not eligible for medicaid. This man would contribute some on a sliding scale, from, I believe, $7,500 down to zero and would be scaled down according to his income.

Mr. Florio. You are talking about the deductible portion?

Mr. Carter. Yes, sir.

Mr. Florio. Over and above the deductible there is another contributing part a person enrolled in AHIP makes?

Mr. Carter. No; he would pay part of this himself, but he would be assisted by Federal funds in paying this if his income were less than $7,500, but it is not medicaid.

Mr. Florio. There is no State contribution?

Mr. Carter. There will be no medicaid in this.

Mr. Florio. With regard to this proposal AHIP, there is no State contribution as there is with medicaid?

Mr. Carter. Up to 25 percent, based on a formula.

Mr. Florio. So, then, essentially, we are talking about the same system, same form, as medicaid, except what you have done is add now a responsibility on the part of the recipient. the beneficiary to pay a portion of the cost over and above that he has to pay deductibles and coinsurance?

Mr. Carter. That is quite true.

Mr. Florio. Well, without going into it, my thoughts with regard to the desirability of that approach, I was just wondering if you find any inconsistency between requiring that there be no deductibles and no coinsurance provisions for preventive care?

Mr. Carter. Yes.

Mr. Florio. When a person does actually become sick—and you said you didn't want to discourage anyone from taking advantage of that—at the same time, when we go to the actual treatment, when an individual is sick, then we have the deductibles and coinsurance, ostensibly for the purpose of discouraging the utilization of facilities.

Do you have any difficulties with that?

Mr. Carter. Yes; there is a problem there. However, we hope, if they use preventive medicine, there won't be so many of them who would be sick. And not only that, whenever they do take advantage of this, they have other benefits, including prescription drugs, for instance. In addition to that, they also will have catastrophic illness coverage, which is not covered at the present time, except in the case of medicaid.

Mr. Florio. Just in conclusion—with all due respect, my main difficulty with the whole approach of this bill and the administration's bill, in the past, is, I really don't think enough emphasis is placed upon basic reform, cost control, that, I think, we are really saying—I assume what you are trying to do is, expand coverage and provide maximum benefits, but we are not talking about the utilization of our health dollar in the way that we should be.

I think, what we have been doing, over the last number of years, is, in many respects, not getting the maximum benefit for our health dollar in terms of rationalization of health services. I really don't see where this makes any monumental reforms, any changes in terms of allocation of our dollars.

I am very happy about the fact that you have talked about preventive medicine. I think that is something that is desirable, but I don't see this incorporating into the overall health system in this country major incentives to keep people out of hospitals rather than putting them into hospitals.

Reliance upon the existing system of private carriers is not going to do any good, because that is the thing that has got us into trouble in terms of escalating costs of health in this country. So, though I commend your effort, particularly your addition, at least, acknowledgment of preventive medicine, I am not sure I regard this as sufficiently significant in terms of a change from the existing system. But I think it is costing us entirely too much.

Mr. Carter. Well, certainly I don't think this would cost nearly as much as many of the bills that are before us. In fact, much less. And while there are some disincentives—that is quite true, in our present state of financial condition certainly we can't afford everything that we would like to afford.

We could cover everybody and at a tremendous cost, and perhaps there are some of us who would want to. But where is the money coming from?

We do have a great difficulty in getting capital now, and this is a modest proposal. It is an alternative, and it certainly doesn't cost nearly as much as some of the other plans would.

At the same time we will have controls at the State level. I certainly don't think that people will be encouraged by this to overutilize hospitals. I believe there will be cost controls.

Mr. FLORIO. Thank you.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman, and I certainly commend you, Dr. Carter.

Mr. CARTER. Thank you, sir.

Mr. PREYER. I think the bill has the kind of thoughtfulness and compassion that we have learned to expect from you.

Mr. CARTER. Thank you, sir.

Mr. PREYER. On the subject of cost control, do you use the PSRO mechanism?

Mr. CARTER. The PSRO mechanism is already a part of the law, and this does nothing to abolish that. Of course, it also applies it for outpatient care.

Mr. PREYER. Do you think that the experience we have had with PSRO's so far justifies our relying on them for quality review under national health insurance?

Mr. CARTER. I certainly feel that PSRO could be improved tremendously, and, certainly, the amount of paperwork that is required by many of our physicians is tremendous. I hope some other mechanism could be found, yes, sir.

Mr. PREYER. Your bill is somewhat like the administration's bill. The administration's position seems to be we shouldn't go ahead with national health insurance at this time?

Mr. CARTER. Yes, sir.

Mr. PREYER. What is your feeling about that?

Mr. CARTER. Well, I have offered this bill as an alternative. If we are to consider something, I think it must be within certain financial constraints. We just simply can't do, at the present time, as much as we would like to do and go as far as we would like to in this area.

Mr. PREYER. Do you feel that probably we will have to delay this for a year or two?

Mr. CARTER. That is my feeling, the way it is at the present time, yes, sir.

Mr. PREYER. One more question before we vote?

Mr. ROGERS. Yes.

Mr. PREYER. Since you are a physician and we don't always get to question them, I think we would be interested in your views on how physicians would react to the various bills, including your own, which have been introduced?

Mr. CARTER. Well, I feel that they would regard it among one of the better bills which have been offered, though, many physicians would not want any.

But I think the majority realize that there will be a health insurance bill whenever the finances of our country permit, and it is my understanding that they do not look with disfavor upon this proposal.

Mr. PREYER. Thank you.

Mr. ROGERS. Mr. Scheuer.

Mr. SCHEUER. Well, I appreciate our colleague giving us his wisdom and learning in the health sciences.

Under the Employee Health Insurance Plan, to be eligible, apparently, the workers would have to meet the full-time hours of work tests, is that correct?

Mr. CARTER. No, sir, I don't believe that is exactly right.

Mr. SCHEUER. How would this work?

Mr. CARTER. To qualify as an eligible full-time employee the employee must work for at least 25 hours per week for at least 10 weeks, or a total of 350 hours.

Mr. SCHEUER. What is the work test involved, and how would it be administered?

Mr. CARTER. Of course, the information of necessity would be obtained from the employer and would be relayed to the insurer.

Mr. SCHEUER. Under the Assisted Health Plan, as I understand it, very high-risk working families and nonworking families with unusually high medical risks, regardless of income, and unusually high-risk employer groups, are all eligible?

How do you define "high-risk", and how would this definition be implemented?

Mr. CARTER. "High-risk", of course, would include those who are not insurable in other ways. You take a man with a heart condition, or something of this nature, who would otherwise be uninsurable, this would cover him.

Mr. SCHEUER. Would this plan provide comprehensive coverage for families below the poverty line?

Mr. CARTER. Yes.

Mr. SCHEUER. How would it provide coverage for families below the poverty line, when with the 25 percent coinsurance feature they would have to pay perhaps as high as $1,000 or even more?

Wouldn't this be an unsupportable burden for poor persons?

Mr. CARTER. I believe that the amount charged to a poverty patient would be as litle as $100 per year.

Mr. SCHEUER. Would they be exempted from the coinsurance feature?

Mr. CARTER. In this case they would not and also——

Mr. SCHEUER. Wait a minute. If they are not exempted from the coinsurance feature which could run them up in the neighborhood of——

Mr. CARTER. Ten percent at the lowest, yes, sir, that is right. Up to 25 for the $7,000 level of income.

Mr. SCHEUER. That 25 percent could bring their contribution to $1,000 or conceivably higher; that is a pretty big belt, isn't it?

Mr. CARTER. Well, that would be the maximum liability for one with $7,000. But actually with this plan, you have a lot more pluses. This includes catastrophic illness which is not otherwise covered by this.

Mr. SCHEUER. One last question.

How would you say your legislation adds incentives to control cost? How could we do more for the same money we are spending now, or do what we are doing now at less cost?

Mr. CARTER. By two ways. First, by prevention, by preventing the occurrence of illness, and second, by the coinsurance disincentives, a person would not go to the doctor unless it was necessary.

First, the prevention package is free, it doesn't cost the enrollee anything, only the employer and the Federal Government. Second, it prevents unnecessary visits to the physician or hospital.

Mr. SCHEUER. And how does it prevent that?

Mr. CARTER. First, you try to keep your patients healthy. That is No. 1.

Second, you do have a disincentive because there is a minimum charge of cost sharing. Individuals would tend to be more cautious about going to the the doctor.

It has been estimated by some physicians, as many as 70 percent of the patients who come in to see them are really not physically ill.

Mr. SCHEUER. Thank you very much.

Mr. CARTER. Thank you.

Mr. ROGERS. Dr. Carter, thank you so much.

We have a vote. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

Without objection, the Chair wishes to place in the record, as though read, a statement submitted by Congressman Al Ullman of Oregon, the chairman of the Ways and Means Committee.

STATEMENT OF HON. AL ULLMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. ULLMAN. Mr. Chairman and members of the subcommittee, I am pleased to be able to share with you my thoughts on national health insurance and in particular to discuss my proposal, the "National Health Care Services Reorganization and Financing Act," which has been introduced as H.R. 1.[1]

It would be a serious mistake, I believe, to simply pour more money into the financing of health care services for the American people without taking appropriate steps at the same time to improve the organization of health care delivery in this country. One reason is that even with insurance, you cannot buy health care that is simply not available where you live. We need better distribution of health care personnel and facilities, so that care of good quality will in fact be available to people in rural and inner city areas where there are shortages today. A second reason is that better coordination of health services can help to bring improved care, not just in shortage areas, but for everyone. Better coordination also should enable health care to be furnished more efficiently, and thus help to hold down increases in health care costs.

As Chairman Rogers stated in announcing the subcommittee's hearings, "It would be a hollow accomplishment to devise a financing mechanism if we did not have the proper supply of manpower, facilities and resources to make the system work." It is quite appropriate for your subcommittee to concern itself with these important health resource issues in the context of national health insurance. It is also important, I believe, that there be a coordinated national effort to plan and carry out a national health policy. My proposal, H.R. 1, directly addresses these issues of health resource organization and health policy formulation and implementation. I commend H.R. 1 to the Congress and the American people as a serious effort to point the way toward constructive solutions to our health care problems, but I also want to make it clear that I view my bill, as others should be viewed, not as a finished product but as an invitation to comment and thought.

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[1] See p. 302 for full text of H.R. 1.

As the subcommittee knows, my bill contains an important new concept, an administrative entity known as the health care corporation or HCC, which is intended to be the focal point for the coordination of community health services. The HCC represents, I believe, an exciting new concept of responsible localism. It would be built upon the existing delivery system, but with mandatory reorganization and reorientation to meet local needs, under the supervision of newly established State health commissions.

HCC's would be organized in a variety of ways determined largely by community needs, custom, and precedent. They would grow out of the community, providing for citizen or consumer representation on their governing boards and being accountable to the public. It is expected that they would primarily be organized by health care providers—hospitals, doctors, dentists, as well as nursing homes and community health organizations—working with the community to establish a more effective, coordinated system.

Every HCC would have to provide, within a State plan administered by the State health commission and approved by the Secretary of the Department of Health, a comprehensive benefit program for all persons in its service area who wished to register. After the first 5 years of operation, it would be required to offer as an option to its registrants, services on a capitation basis of payment, or so much per person per year, a method of payment that requires providers of service to accept a direct responsibility for utilization and cost of services. Among its responsibilities, the HCC would be charged with encouraging the development and use of outpatient services, and for seeing that the most appropriate service would be provided for patients in the most effective, least costly way.

Every employer would be required to purchase for his employees and their families a comprehensive level of benefits as prescribed in the legislation and within regulations issued by the Secretary of Health, paying at least 75 percent of the premium costs. The employees would pay a maximum of 25 percent. For individuals and their families who registered with HCC's, the Federal Government would contribute 10 percent of premium costs. To assist the self-employed and small employers in meeting premium payments, my proposal also includes a special tax credit mechanism. Special provisions would assure the same level of protection for people who cannot obtain protection through a place of employment, and special help in meeting premiums and copayments would be afforded low income people.

The approach taken by H.R. 1, then, in improving the organization of health care delivery, is based upon the HCC as the coordinator of local community health care resources and upon a strong role for responsive State and local implementation (under Federal guidelines) instead of reliance on a massive Federal bureaucracy. Let me call attention to some specific features of the bill aimed at assuring the availability of health care resources and their efficient and prudent utilization.

First, HCC's could offer to their registrants an option under which they would receive their health services on a prepaid capitation basis and after 5 years of program operation, HCC's would be required to make this option available. The incentives for efficient operation and for control of unnecessary utilization that derive from the prepayment approach are fully known to members of this subcommittee, as is demonstrated by your work on HMO legislation. I am hopeful that competitive forces will help to control costs and promote efficient delivery of health care not only under prepayment, but also in the fee-for-service system that will continue to exist in competition with the prepaid capitation approach.

Second, H.R. 1 strongly encourages use of outpatient services including a wide range of health education services. HCC's are required to emphasize outpatient care and to periodically schedule health maintenance services. They must see to the development of outpatient care centers to provide health maintenance services and community-based services such as home care, medical social services, and the services of well-baby clinics and mental health clinics. HCC's would also be required to undertake continuing programs of health education for their registrants and to collaborate in communitywide health education efforts of public and private organizations. These provisions reflect the direction in which I believe we should be heading—toward greater emphasis on prevention and health maintenance, and toward more widespread and effective health education designed to enhance access to the appropriate forms of care and encourage the prudent use of health services.

Third, the Secretary would be charged with supporting, through financial and technical assistance, the establishment of the system of comprehensive health care delivery contemplated by the bill, including the provision of incentives for the use of the capitation payment method, and the development and improvement of outpatient care centers, particularly in poverty and rural areas, and the development of home health agencies. He is charged also with conducting a continuing study of the operation of the health care delivery and financing system established under the proposed program and is further authorized to study alternative methods of furnishing and financing health care services, and methods of improving the delivery of services.

Fourth, the bill would support the orderly growth and expansion of needed health care facilities through adequate reimbursement that takes into account actual or proposed capital expenditures. The bill is squarely in line too with the philosophy of the planning legislation handled by your subcommittee, which intends to prevent wasteful and costly expansion of facilities in excess of the capacity that is needed. I believe strongly that appropriate philanthropic support for health care facilities and services should be continued and expanded, and the bill contemplates that this should happen, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health services. In addition, the bill calls for a special study and investigation of methods for assuring an adequate supply of supplemental capital and other funding, with special emphasis on high priority health care needs, both rural and urban.

Finally, I believe it is essential that in the health area, the Federal Government get its own house in order. Accordingly, the bill calls for the establishment of a new Department of Health, to be headed by a Secretary of Health responsible to the President. Although my bill places major responsibility at the State level and retains a strong role for the private sector, the Federal reorganization provided for in the bill reflects my conviction that the Federal health policy role must be effectively carried out, and that the Federal Government needs to organize itself to manage efficiently the variety of health programs to which it is committed.

Although I have chosen in this statement to focus on the provisions of the National Health Care Services Reorganization and Financing Act that relate to the Nation's system of health care delivery, I urge attention also to other features of the bill that I have outlined elsewhere. Suffice it to say that the bill would provide comprehensive health benefits for all, including protection against catastrophic health care costs. It would do this in a way that reasonably balances public and private roles, and is implementable now because the structure the bill defines is based on existing resources. The bill reflects a pluralistic approach to health care services and the delivery system. It preserves freedom to choose among health care providers and underwriters of health benefits. It is founded upon the recognition of health care as an inherent right of every person, and the principle that the same scope of comprehensive health benefits and the same high level of quality of care must be available to all. And it is deliberately staged in over a period of 5 years so that the existing system will be able to make the required changes in an orderly and systematic way.

As I have indicated, I present this proposal as an invitation to thought and comment rather than as the only answer to the problems we face in the area of health care delivery and financing. But I do believe it represents a sound and constructive proposal that is comprehensive in scope and which can begin to be implemented now because it builds upon the existing structure. We cannot postpone much longer the major decisions that are needed to reorient our system of health delivery and bring into being a more equitable system for financing health services for all the population. We need to act soon to put in place a program of national health insurance for the American people.

Mr. Rogers. The next witness will be Mr. John Alexander McMahon, president of the American Hospital Association.

We welcome you to the committee, along with any associates you may have with you.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY MICHAEL M. HASH, DIRECTOR, DIVISION OF LEGISLATION

Mr. McMahon. Thank you, Mr. Chairman.

Mr. Rogers. Your statement will be made a part of the record in full, (see p. 165), and you may proceed as you desire.

Mr. McMahon. Thank you, Mr. Chairman.

What I intend to do is just summarize the high points of the statement in those areas I think that will be of most interest to you.

As you indicated, Mr. Chairman, I am Alexander McMahon, president of the American Hospital Association, accompanied by Michael M. Hash, director of the Division of Legislation, in our Washington office.

The association membership, which consists of 7,000 member institutions, including most of the hospitals of the country, extended long-term care institutions, mental health facilities and hospital schools of nursing, is deeply committed to providing high-quality health care to all people at a reasonable cost.

We welcome this opportunity to testify on national health insurance before your committee and to express our views on the crucial issues of organizing, delivering, and financing health care services to meet national health care needs.

I appreciate the fact that you will include the full statement in the record, Mr. Chairman.

Mr. ROGERS. Yes.

Mr. McMAHON. I noted, on the bottom of the first page and the top of page 2, the way we developed the policies on national health insurance of the American Hospital Association, noting that it went on over a substantial number of years, and with the changes—particularly some of the changes being made by this committee—in manpower and facilities and planning, we continue to adjust that original statement to the changing world.

On pages 2 to 4, I set out the basic underpinning, Mr. Chairman, of the way we went about determining the policy of the American Hospital Association, and I noted on page 2 the way we began by identifying three specific problems.

First, the uneven access to health care services observed and experienced by many people. Adequate and equitable access to care is precluded for a variety of reasons for many people; shortages and maldistribution of manpower, on which you all have worked, shortages and maldistribution of facilities and lack of coordination of services by health care providers and planners, and so on, as this committee has well known, because it has addressed itself to many of those problems one at a time.

You have recognized, as do we, there is still uneven access to health care services. We also recognize the very real problem of the rising costs of health care. The problem of dealing with rising costs is complicated by the fact that the real causes of rising costs are not well understood and the rise is sometimes treated as a simple change in pricing or the fact that the mix of services, as Dr. Carter knows, is changing as we take advantage of new developments in the technological area that makes it possible for us to take more and better care of more people all the time.

I mention, on page 3, the regulatory fragmentation that gives us tremendous problems, because health care providers are subject to a host of regulations and guidelines and standards and audits and surveys promulgated not only by governmental groups, but by professional accrediting groups, as well.

So that, we began saying that any national health insurance plan would have to deal with those three problems, and we went on to conclude that a comprehensive national health insurance program would have to achieve specific goals: first, improving the structure of the system, second, increasing the accessibility of high quality care, third, bringing some relief from duplicative and conflicting regulatory action, and, finally, assuring equitable and adequate financing for health care services.

And we think all of these problems must be recognized and certain goals must be set out and the coverage, the regulatory, and the financing decisions, must then follow along.

On the top of page 4, I set out a number of things that we think any national health insurance program ought to do.

First, it ought to provide universal coverage for all Americans, through comprehensive health benefits, including comprehensive coverage of both impatients and outpatients and coverage of acute illness as well as preventive care extending to illness that results in catastrophic cost. It should provide for equitable and adequate financing by obtaining contributions from multiple sources of funds, both government and private. It should provide for the integration and coordination of all key elements of the health care system, including the means for delivering health services, the mechanism for financing and payment for services and regulatory and administrative structure.

It should provide for the preservation and encouragement of philanthropic giving for health care facilities and services. It should provide for a better organized, more productive health care delivery system, to assure that health resources are used effectively in making health care available, accessible, and provided in a manner that is acceptable to both consumers and providers, and, finally, it should provide an appropriate means to insure the rendering of high quality health care in the most economical manner.

H.R. 1,[1] the National Health Care Services Reorganization and Financing Act, introduced by Congressman Al Ullman, chairman of the House Committee on Ways and Means, incorporates provisions which appropriately address the key issues the American Hospital Association believes must be dealt with in any national health insurance program, and we very strongly support that bill.

Now, if I may, Mr. Chairman, I would like to discuss some of the specifics of H.R. 1 and the principles we espoused dealing, first, with the coverage of basic benefits—and that is set out in my full statement, from pages 4 to 6.

As I noted, one of the important objectives is to make a high level of comprehensive health care benefits available to all persons, the employed and unemployed, aged and young, the disabled and the well, and persons of all income levels, including the poor and the near poor. And we may want to get into some of those details later on.

The benefits package of any national health insurance program should be comprehensive and include many components—in other words, to maintain personal good health and to prevent illness, to provide primary, specialty, restorative, and health-related custodial care and cover all illnesses, including those which result in catastrophic cost.

Finally, it should make available health services in both ambulatory and institutional settings to meet the needs of the patient.

I went on in my statement to mention some of the aspects of it that were explored earlier by the committee of cost sharing, believing, as

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[3] See p. 322 for full text of H.R. 1.

we do, that deductibles present high administrative costs, and yet modest copayments imposed at the time of service both reduce the cost of the insurance program and provide an involvement for the individual in the costs of his care at that time.

We do believe that some cost sharing, as I noted at the top of page 6, is both appropriate and desirable, both for the financing of services and for assuring that individuals share to the extent possible in the cost of their own care.

We, in addition, support the health care approach that has been included in H.R. 1 and a number of other national proposals as an important mechanism for reducing barriers to care and for increasing the administrative efficiency in the overall payment system, while still involving an individual economically at the time of his service needs.

We give some specific attention to the concern people have for catastrophic coverage, Mr. Chairman, beginning at the bottom of page 6 and for the following page or two, and it may be worthwhile going into some of the details there.

We believe that any national health insurance program should provide coverage for illnesses which result in expenses that are catastrophic to individual and family resources. We are convinced that catastrophic coverage must be made part of the comprehensive benefit package that would be made available to all persons, rather than provided as a separately financed and administered benefit, and I have given three reasons for that.

At the present time, 80 percent of the people in this country have insurance coverage for hospital services, and a separate catastrophic program would duplicate much of this coverage and merely lead to a downward revision of some private employer-employee health insurance policies.

Second, the catastrophic coverage programs that have been proposed do not incorporate support for improvements in the health care delivery system that we believe are needed if national health insurance is to be successful.

Finally, the separation of catastrophic coverage from basic benefit coverage would create additional administrative expenses, duplicate recordkeeping and claims processing and so on.

Now, if we might turn over to page 8, Mr. Chairman and members of the committee, to some comments on the development of health resources.

A national health insurance program providing comprehensive benefits to all, when it is enacted, is certain to result in an increase in demand on health care facilities and services, and to meet this demand the health care delivery system will need a greater capability, especially for providing outpatient or ambulatory care services. Authorized benefits must be matched with available and accessible services and a program should not be enacted that will promise more than it can deliver.

As I note on page 9, we believe it is essential that national health insurance legislation include provision for the development of health resources in such areas as the health systems' manpower, facilities, communications and transportation—many areas to which this committee has given its attention. And we think that these provisions should be coordinated with other programs to assist in the development of health resources, and H.R. 1 seeks to deal with this issue and calls for a special study to develop a program to provide funds for resources to meet high priority health service needs in underserved rural, as well as urban areas.

Beginning on page 9, Mr. Chairman, we have addressed the issue of the health delivery system. Needed health resources come into sharp focus when we examine the issues and problems now confronting our health care delivery system. In addition to the development of a benefits package that is as comprehensive as possible for the total population, there must also be assurances that the actual services will be available and accessible. It is our assessment that the existing system could not fully and immediately respond to the increased demand that will inevitably follow the enactment of national health insurance.

We believe, firmly, that the private sector can and will meet the Nation's health care needs, given an appropriate support for the development of necessary resources. But to do so existing institutions and individual professional providers of health care services will need to improve the coordination of and access to comprehensive health care services.

We believe that in our policy statement we have developed an innovative approach called the "Health Care Corporation Concept", and I would like to cover some of the important parts of that concept.

A health care corporation would be a community based, not for profit, private or governmental organization, that would synthesize local health resources for the delivery of comprehensive health services to defined population groups to better meet the health care needs of the community. It would serve specific geographic areas and provide comprehensive health services through their own facilities and/or through affiliation with other providers.

Every health care corporation would have to make available high quality, comprehensive health services to all persons residing in its service area who would wish to register with it. These services would range from health maintenance coverage to coverage for illnesses with catastrophic costs and would be provided through use of the outpatient or inpatient facilities most appropriate to the patient's needs.

These corporations would span political boundaries where necessary, to assure that all persons had access to care, both rural and urban. They would provide an especially valuable service in underserved areas, both rural and urban, where they would provide an important link to a comprehensive health care system for individuals residing in these areas and also for health care professionals in those areas who may be isolated from the mainstream of the health care delivery system.

The goal of the HCC provision contained in H.R. 1 is to bring about the establishment of health care corporations in all areas of the country. This would provide the public an opportunity to choose between the services of these comprehensive delivery organizations and of traditional, independent providers of care. In some areas there would even be a possibility of selection between HCC's.

The HCC concept is designed to take significant steps toward solving the problem of access to care, which is a serious problem today, and may become even more critical when broad-scale benefits and financing for them are extended through national health insurance to the entire population.

We believe that the geographic responsibility of the HCC is a realistic approach with substantial promise for assuring that services would be available to all.

HCC's like HMO's would be responsible for providing a comprehensive range of services for all of its registrants, so that, from the consumer's viewpoint, a single identifiable and accountable organization would be responsible for meeting all of the health care needs.

Finally, coordination and planning of services on a local, State and national basis can be improved through the implementation of this concept. The HCC, through its responsibility for a specified geographic area, would result in a nationwide system for the delivery of comprehensive services, in contrast to the more limited HMO concept.

Such a system would be created through the combination of HCC development and planning for a geographically defined population groups and a State based regulatory process responsible for assuring that all areas within each State would be covered without any unnecessary duplication of facilities or services.

In the next eight pages, Mr. Chairman, we have dealt with the issue of financing. We have pointed out, for example, that we think a variety of sources of funds must be available, governmental funds as well as contributions from employers and employees.

I have noted some of our concerns with a Federal system involving the trust fund approach, beginning at the bottom of page 12.

First, the trust fund approach would create inflexibility in the development of and underwriting of health insurance benefits. The manpower, facilities and equipment that would be required to administer a national health insurance program through a single governmental agency covering 200 million persons staggers the imagination, and I noted on page 13 that in a study ordered by the House Ways and Means Committee, the General Accounting Office found the Government spends nearly twice as much as private insurance carriers in processing medicare claims. We think to dismantle a substantial portion of the existing carrier machinery makes little sense.

Third, the Federal trust fund approach would require an assessment of the needs of the group served—a difficult, if not impossible task, when that group consists of more than 200 million people. And I would suggest, Mr. Chairman, that, in adition, it would undermine the planning concept that we put into operation, because if planning is to work, then the decisions must be related to the money in a specific area and this can only be done with a State and local structure, where through insurance premiums the people would pay for the system that they themselves had had a hand in bringing about.

Toward the bottom of page 14, I noted another consequence, and that is the inequity of imposing taxes for health insurance on individuals and on employers without relation to the number of beneficiaries covered, or to the utilization of services by the covered worker and his family.

I have noted, on page 15, that while some have argued that the Federal system approach would remove a disincentive for employment of the physically handicapped, it is our position that, when you spread it over an employee group, that the cost of including coverage for the physically handicapped becomes quite low.

As a final point, proponents of the Federal trust fund approach argue that it is the only way to assure that all persons would have access to the same level of comprehensive benefits; but we believe that that can be accomplished without the inflexibility of a single mechanism by providing universality of coverage, irrespective of income level, age or other variables—which I have noted the key elements on page 15—by mandating or placing a strong financial incentive for the viability of health insurance benefits for the employee, extending these benefits to persons who become unemployed, providing statewide pools for group insurance available to the self-employed and small groups and uninsurables, providing coverage for low-income persons financed through general tax revenue, primarly Federal, and continuing the existing social security tax mechanism for the aged and disabled.

Mr. Chairman, on page 16, I have noted—and we don't need to dwell on the details, unless there are questions later—on the importance of philanthropy.

H.R. 1 contains some specific provision to continue the encouragement of philanthropy itself and the flow of philanthropic dollars into the system.

On pages 17 and 18, I have noted the need to address the issue of the financial requirements of health care institutions. We believe that any national health insurance bill must spell out the elements of financial requirements for health care institutions in some detail.

We recommend that language be included in the bill that is developed to adequately define those requirements, and I have set forth the requirements as we see them at the bottom of page 17 and the top of page 18.

Throughout the Nation, institutions and other health care providers are being paid for their services under a variety of systems, ranging from retrospective cost-based reimbursement, to prospective payment systems. And after identifying some of the different prospective payments systems. I noted, on page 9, that we favor the use of the prospective payment mechanism under national health insurance.

On the other hand, because of the variety of approaches available under this prospective label and because of the relative newness of these approaches, it appears premature to mandate in any national health insurance law the use of a single specific method of prospective payment to institutional providers of service. Therefore, it is our view that any national health insurance program should provide for the establishment of one or more payment methods within each State—payment methods that are to be developed on a State-by-State basis, in accordance with regulations of the Secretary, could be based on budget review, on target rates, on negotiations, formula, or other appropriate methods.

States should be permitted to develop more than one system, and where this occurs, providers should have the option of selecting from the alternatives.

Once the system or systems were established in the State, they would apply uniformly to all payers, including the Federal Government.

Mr. Chairman, from pages 20 to 22, we have noted some of the problems with regulation of the system and some of the things that we think ought to be addressed because of the existing fragmentation that I mentioned earlier. The Federal Government, as we see it, must play a pivotal role in any national health insurance program with efforts directed toward determining the basic level of health benefits, establishing the scope, standards of quality and comprehensiveness of health services. Although we believe that control mechanisms are best implemented at the State level rather than federally, the Federal Government should assure that the responsibilities and administrative structures of State agencies provide a reasonably uniform operation of the regulatory process throughout the country.

We have gone on to mention, in the next several paragraphs, some of the specific things that we believe the Federal Government should have as its responsibility.

Then, on page 21, we address the issue of State regulation, because we believe under appropriate Federal guidelines that review of provider rates, certificate of need and planning activities, utilization controls and controls over insurance premiums and benefits, should be focused at the State and local level.

Once again, this tying back to financing would tie controls and financing more closely together.

State and local control is essential in order to appropriately reflect social and economic variations from community to community and among the States across the country.

We believe that through the delegation of regulatory functions to State and local agencies a process can be developed that would be more truly responsive to the real needs within each community. Extensive, complex Federal controls would be inflexible and inadequate in view of the diverse and highly varied nature of communities in different parts of the country and the ways in which they choose to meet their health care needs.

What works well in densely populated urban areas won't always work well in small towns located in a rural area, and we have gone on to set forth on page 22 some of the State activities—they are gaining in experience in this area.

The 27 States, for example, with certificate of need programs, some of those that are working in the area now of budget review and rate review as well.

And I noted in the middle of page 22, that another example of the delegation of regulatory authority to State and local levels under Federal guidelines is the establishment of the PSRO mechanism.

Mr. Chairman, at the bottom of page 22 and the top of 23, we have noted some of the problems in implementation of national health insurance, noting that while we believe that it is timely to debate the various aspects of national health insurance, that probably the time is here to go ahead, remembering that we could stager a national health insurance program in over a period of years, in order to lessen the sharp impact that a program put into effect all at once would have.

In conclusion, Mr. Chairman, the American Hospital Association believes that our recommendations for dealing with the key issues herein set forth are reasonable and workable solutions to the problem of health care delivery financing and regulation, and constitute a program that would meet this Nation's health care needs. We support and commend to this committee the approach of H.R. 1, which provides for comprehensive health benefits for all Americans, for restructuring the health delivery system, for an equitable and adequate financing system and regulatory system to be implemented at the State level, and for a necessary phase-in period.

We appreciate this opportunity to present our views on national health insurance and stand ready to assist the committee further in any way we can.

[Mr. McMahon's prepared statement and attachment follow:]

STATEMENT OF JOHN ALEXANDER MCMAHON, PRESIDENT, THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association.

The Association's membership, which consists of some 7,000 member institutions including most of the hospitals of the country, extended long-term care institutions, mental health facilities, and hospital schools of nursing, is deeply committed to providing high quality health care to all people at a reasonable cost. We welcome this opportunity to testify on national health insurance before your Committee and to express our views on the crucial issues of organizing, delivering and financing the delivery of health care services to meet the national health care needs.

DEVELOPMENT OF AHA POLICY

The American Hospital Association has developed a broad framework for a system of organizing, delivering, financing and regulating health services that is embodied in the Association's *Policy Statement on Provision of Health Services*, (1971), a copy of which is attached. This statement is the product of efforts that began some six years ago with a detailed study and review of the nation's health care system by a special committee named by the Association's Board of Trustees to determine how the system might be made more effective and more comprehensive, and provide better health services for all people. Earlier this year the principal elements of the *Policy Statement* were reaffirmed in the attached *Summary of Principles for a National Health Insurance Program* (1975).

GOALS AND ISSUES

The Association in formulating its recommendations sought to address the major problems facing the health care system. In general terms these problems can be summarized under three headings.

Uneven access to health care services

Adequate and equitable access to health care is precluded for many people for a variety of reasons, for example, shortages and maldistribution of manpower and facilities; lack of coordination of services by health care providers and planners; and inadequate financial resources to pay for needed services. There has been a failure to integrate planning with the process of providing services so that (1) a practical plan for distributing services is developed, and (2) the plan is carried out by providers.

Rising costs of health care

This is a major concern because of the burdens that rising costs place on the public. Increases in the cost of health care fall directly on self-pay patients, necessitate higher premiums for hospital insurance in order to preserve existing benefits and add to the cost of the Medicare, Medicaid and other government programs. The problem of dealing with rising costs is complicated by the fact that the real causes of rising costs are not well understood and the rise is sometime treated as simple change in price. When inflation is responsible for about 50 percent of the increase in health care costs, an equally important factor has been the changing character of health services resulting from new and expanded services to provide better care for patients.

Regulatory fragmentation

Health care providers are subject to a host of regulations, guidelines, standards, audits and surveys promulgated or conducted by professional and accrediting groups and by various agencies of local, state and federal governments. These regulatory activities are often duplicative and conflicting.

While much has been accomplished by the health care system in recent years in dealing with these issues, we all know that many basic problems remain. These persistent health care problems must then be carefully addressed in the development of a national health insurance program.

Evaluation of the national health insurance proposals found in various bills must be done in relation to the goals that should be achieved. Our Association has outlined a comprehensive national health insurance program which could be a lever to achieving the following goals: improving the structure of the system, increasing the accessibilty of high quality care, bringing some relief from duplicative and conflicting regulatory actions, and assuring equitable and adequate financing for health care services. Implicit in our plan is our strong belief that to be viable national health insurance legislation must address the major issues and problems within the health care system and provide for an integrated and coordinated program. We do not believe that a piecemeal approach is advisable. We believe it will not work, and that a legislative program which addresses only some of the problems can only further exacerbate and perpetuate a fragmentation of health care services. We believe that in order to provide a workable solution to the problems we face in the delivery of health care and in the financing and regulation of the health care delivery system, the program should:

Provide universal coverage for all Americans through comprehensive health benefits, including comprehensive coverage of both inpatient and outpatient services and coverage of acute preventive care for illneses that result in catastrophic costs;

Provide for equitable and adequate financing by obtaining contributions from multiple sources of funds, both governmental and private;

Provide for integration and coordination of all key elements of the health care system, including the means for delivering health services, the mechanisms for financing and payment for services, and the regulatory and administrative structures;

Provide for preservation and encouragement of philanthropic giving for health care facilities and services;

Provide for a better organized, more productive health care delivery system to assure that health resources are used effectively in making care available, accessible and provided in a manner that is acceptable to both consumers and providers; and

Provide appropriate means to ensure the rendering of high quality health care in the most economical manner.

H.R. 1, The National Health Care Services Reorganization and Financing Act, introduced by Congressman Al Ullman, Chairman of the House Committee on Ways and Means, incorporates provisions which appropriately address the kay issues the American Hospital Association believes must be dealt with in any national health insurance program. The AHA strongly supports the bill. I shall now describe for you these essential provisions.

COVERAGE AND BASIC BENEFITS

Coverage

One of our important objectives is to make a high level of comprehensive health care benefits available to all persons—the employed and the unemployed; the aged and the young; the disabled and the well; and persons of all income levels, including the poor and the near-poor. With national health insurance we can and should close the gaps in the current health insurance system through provisions for coverage for those who become unemployed, for the self-employed, for small groups, and for "uninsurable" segments of the population. We should eliminate the great variations among the states in benefits for the poor by federal financing of the same level of benefits for them as for the working population. Thus, through various financing methods, a uniform level of benefits for all persons would be assured, irrespective of income category, age, employment status, or other such variables.

Benefits and cost-sharing

The benefits package of any national health insurance program should be comprehensive and include such components as are needed to maintain personal good health and to prevent illness; provide primary, specialty, restorative and health-related custodial care; cover all illnesses including those which result in catastrophic costs; and make available health services in both ambulatory and institutional settings to meet the needs of the patient.

The AHA recommends that no distinction be made between benefits for acute physical and benefits for acute mental illness. Recent studies, including one conducted by the AHA,[1] have shown that benefits for acute mental illness are insurable at a reasonable cost and that there are no rational grounds for providing only a relatively limited level of benefits for acute mental illness in national health insurance.

The imposition of a substantial cost-sharing requirement through deductibles and high copayments recommended in some national health insurance bills concerns us in two ways. First, the administrative cost of implementing a deductibles program is too high. The cost will be found to be substantial in comparison to the dollars saved through the use of deductibles. Second, a high level of deductibles and copayments could become a barrier to individuals seeking or receiving needed health care services. The out-of-pocket expenditures required to pay the deductibles could well discourage some individuals from obtaining needed care, as could the relatively high copayment provisions in some proposals. We do not believe that deductibles or high copayments are the most effective means for controlling over-use of medical services since much of medical care use is not determined by the patient. We believe, however, that some cost sharing is both appropriate and desirable, both for the financing of services and for assuring that individuals share, to the extent possible, in the cost of their own health care. We feel that the best approach to achieving equitable cost sharing would be through modest copayments, rather than deductibles. Properly constructed utilization reviews are the appropriate means for preventing over-use.

We strongly support the "health card" approach that is included in H.R. 1 and a number of other NHI proposals as an important mechanism for reducing barriers to care and for increasing the administrative efficiency in the overall payment system. The concept provides for issuance of a health card to each covered individual. This card would be evidence of eligibility for care and would provide for copayments first being paid by the insurance carrier and settled subsequently between the carrier and the patient. This system would eliminate a patient's need for cash at the time of service, would eliminate any "means test" at that time and would transfer the collection function from the provider to the carrier, thus simplifying administration of the program. The development of a mechanism such as this is sorely needed, and is a function that insurance carriers can effectively perform.

CATASTROPHIC BENEFITS COVERAGE

We believe that any national health insurance program should provide coverage for illnesses which result in expenses that are catastrophic to individual and family resources. Further, we are convinced that catastrophic coverage must be made a part of a comprehensive benefits package that would be made available to all persons, rather than provided as a separately financed and administered benefit because:

> At the present time, 80 percent of the people in this country have insurance coverage for hospital services. A separate catastrophic coverage program could duplicate much of this coverage and merely lead to a downward revision of some private employer-employee health insurance policies to conform to the separate catastrophic program.
>
> The catastrophic coverage programs that have been proposed do not incorporate support for improvements in the health care delivery system that are needed if national health insurance is to be successful.
>
> The separation of catastrophic coverage from basic benefits coverage would create additional administrative expense in the health insurance system. Duplicative record keeping and claims processing would result if a substantial portion of the population had basic coverage underwritten by private insurance carriers through employer-employee groups and catastrophic coverage through a government program. Under these circumstances, many

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[1] "Financing Mental Health Care in the United States—A Study and Assessment of Issues and Arrangements." Published by the National Institute of Mental Health, 1973. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

> benefits claims would have to be processed under both the basic coverage and under the catastrophic coverage. The administrative expense of doing this and of determining where liability rests would be substantial as well as confusing to the beneficiary.

Separation of catastrophic coverage from the basic benefits package would create an undesirable rigidity in the system in that private carriers would not be free to develop broad benefits packages that could be adapted to the special needs of various insured groups. In contrast, by requiring comprehensive benefits but allowing maximum flexibility in the design and adaptation of insurance coverage in the private market, substantial advantage can accrue in the form of broader coverage for the same price, or lower prices for the basic level of benefits.

A catastrophic program solely tax-supported would be duplicative in many instances because it would provide benefits that many employers and individuals are now paying for voluntarily, either through group or individual health insurance coverage.

Use of Social Security mechanisms to finance all catastrophic benefits could expand the use of the Medicare retrospective cost reimbursement formula, a mechanism that lacks incentives for efficiency and is inequitable in its failure to bear fully the appropriate share of hospital costs for program beneficiaries.

Also, there are several important deficiencies in the Medicare benefits package, such as the heavy emphasis on acute inpatient services, the lack of outpatient drug coverage, very restricted health maintenance benefits, the split between Parts A and B, and the use of high deductibles and copayments, that should be addressed in national health insurance but would be perpetuated and compounded if a tax-supported catastrophic benefits program were superimposed on the existing Medicare benefits package.

DEVELOPMENT OF HEALTH RESOURCES

When a national health insurance program providing comprehensive benefits to all is enacted, there is certain to be an increased demand on health care facilities and services. To meet this added demand, the health care delivery system will need a greater capability, especially for providing outpatient or ambulatory care services. Authorized benefits must be matched with available and accessible services. A program should not be enacted that promises more than it can deliver. Some of the added services can be provided by using our resources more effectively rather than through an expansion of resources. To this end, support will be required for the development of new, more effective forms of health care delivery and to encourage the growth of existing types of effective delivery organizations. Support is also needed to strengthen many of the progressive moves already taking place in the field, such as mergers, formation of multiple facility organizations and arrangements for shared services.

It is essential that national health insurance legislation include provision for the development of health resources in such areas as health systems, manpower, facilities, communications, and transportation. Further, such provision should be coordinated with other programs to assist in the development of health resources. Inasmuch as your Committee, Mr. Chairman, has jurisdiction over such programs, we know you have wrestled with this problem. As you know, H.R. 1 seeks to deal with this issue and calls for a special study to develop a program to provide funds for resources to meet high priority health service needs in underserved rural or urban areas.

HEALTH DELIVERY SYSTEM

Support for the development of needed health resources comes into even sharper focus when we examine the issues and problems now confronting our health care delivery system. In addition to development of a benefits package that is as comprehensive as possible for the total population, there also must be assurances that the actual services will be available and accessible. It is our assessment that the existing system could not fully and immediately respond to the increased demands that will inevitably follow the enactment of national health insurance legislation. We believe firmly, however, that the private sector can and will meet the nation's health care needs, given appropriate support for development of the necessary resources.

To do so, however, existing institutional and individual professional providers of health care services will need to improve the coordination of and access to comprehensive health care services. We believe that the AHA in its policy statement has developed an innovative approach to resolving these issues through the Health Care Corporation (HCC) concept. This concept is incorporated in H.R. 1.

Definition of the HCC

HCCs would be community-based, not-for-profit, private or governmental organizations that would synthesize local health resources for the delivery of comprehensive health services to defined population groups to better meet the health care needs of the community. HCCs would serve specified geographic areas and provide comprehensive health services through their own facilities and/or through affiliations with other providers, not-for-profit and for-profit.

Every HCC would have to make available high quality comprehensive health services to all persons residing in its service area who would wish to register with it. These services would range from health maintenance coverage through coverage for illnesses with catastrophic costs and would be provided through the use of the outpatient or inpatient facilities most appropriate to the patients' needs.

HCCs could span political boundaries where necessary to assure that all persons have access to care. They would provide an especially valuable service in underserved areas, both rural and urban, where they would provide an important link to a comprehensive health care system for individuals residing in these areas and also for health care professionals in those areas who may be isolated from the mainstream of the health care delivery system. The goal of the HCC provision contained in H.R. 1 is to bring about the establishment of HCCs in all areas of the country. This would provide the public an opportunity to choose between the services of these comprehensive health delivery organizations and of the traditional independent provider of care. In some areas there would be the further possibility of selection among several HCCs.

How HCCs would help meet problems of the delivery system

The HCC concept is designed to take significant steps toward solving two major problems of the health care delivery system—the need for asured access to a comprehensive level of health care for all persons, and the need for greater coordination of services.

> Access to care which is a serious problem today may become an even more critical problem when broad scale benefits and financing for them are extended through national health insurance to the entire population. We believe that the geographic responsibility of the HCC is a realistic approach with substantial promise for assuring that services would be available to all.
>
> HCCs, like HMOs, would be responsible for providing a comprehensive range of services for all of its registrants, so that from the consumer's viewpoint, a single, identifiable and accountable organization would be responsible for meeting all of his health care needs. Thus, an important element for coordinating, on behalf of the patient, appropriate modalities of care, including both physician and institutional services, would be established.
>
> Moreover, coordination and planning of services on a local, state, and national basis, can be improved through implementation of this concept. The HCC through its responsibility for a specified geographic area would result in a truly nationwide system for the delivery of comprehensive services, in contrast to the more limited HMO concept, and insure that each area of the nation would be covered by at least one HCC within a reasonable period of time. Such a system would be created through the combination of HCC development and planning for a geographically defined population group and a state-based regulatory process responsible for assuring that all areas within each state would be covered without unnecessary duplication of facilities or services.

The details of the HCC concept and system can be found in Part II (pages 4–9) of the AHA *Policy Statement*. This concept would move toward resolution of major problems in the delivery of health services in vital ways and should be seriously considered for inclusion in any national health insurance legislation.

FINANCING HEALTH CARE SERVICES

We believe that all persons should be assured of financial access to health care and that no person should be denied health care because of inability to pay. We also believe that there should be adherence to the principle that every person who is able to do so should contribute to the cost of his health care.

Sources of funds

To achieve the dual objective of equity in the distribution of the financial burden and effectiveness in the raising of funds, we recommend that multiple sources of funds should be utilized to finance a national health insurance program, including general federal tax revenues, federal taxes collected through the Social Security mechanism, premium payments by employers and employees, and individual out-of-pocket expenditures. We believe that when health care dollars flow from various sources they help assure the delivery system's responsiveness to local needs. Private charitable contributions also play an important role in the health field, and such philanthropic support should be encouraged.

Some national health insurance proposals would create a structure built upon a single financing mechanism—a new federal trust fund supported by payroll taxes and general tax revenues. Other bills would utilize the existing Medicare system and its trust fund and expand on its base. We have several concerns with a federal system embodying a trust fund approach in whatever form:

1. It would create inflexibility in the development and underwriting of health insurance benefits by (a) sharply reducing the savings that accrue from competition by carriers for employer group health insurance business, savings that currently exist in the form of broader benefits for the same price or a lower price for the same level of benefits; and (b) by restricting the opportunities for savings which are possible in the tailoring of a health insurance package to the specific needs of a particular group.

2. The manpower, facilities, and equipment that would be required to administer a national health insurance program through one governmental agency for over 200 million persons staggers the imagination. Although some advocates of the trust fund approach suggest that this mechanism can provide economies, principally through centralized administration, there is no conclusive evidence to suggest that the federal government can do a more efficient job than private carriers in administering a broad scale program. In fact, in a study ordered by the House Ways and Means Committee, the General Accounting Office has found the government spends nearly twice as much as private insurance carriers spend to process each Medicare claim. To dismantle a substantial portion of the existing machinery in the private market to no productive purpose makes no sense to us. These private sector resources can and should be utilized to the fullest extent.

3. The federal trust fund approach would require an assessment of the needs of the group served—a difficult, if not impossible, task when that group consists of more than 200 million people. After need assessment would follow the problem of establishing a tax rate and tax base to generate the required level of revenue to meet this need. The "pegging" involved would be extremely complex, and the consequence of underestimating the needs would be even more complicated, for if the number of dollars required to actually meet the health care needs for the nation turn out to be greater than the amount projected and made available, the trust fund would become the indirect rationer of health care. Some individuals would then be forced to forego needed health services, and health care providers would be forced to cut back services, or operate at a deficit, or both. Other negative consequences could occur because:

a. A trust fund that is underfinanced would channel revenue on the basis of presumptive priorities. For example, an abnormal share of payments would have to be channeled to certain services, or classes of providers, or classes of patients. This channeling would be done on the basis of priorities decided by the fund's administrators, and those priorities might not coincide with the widely varying needs of beneficiaries in all parts of the country. If the bureaucratically established priorities were askew, the basic underfinancing problem would be further aggravated by the misallocation of scarce funds.

b. A trust fund, falling short of participants' needs, would create a gap between reimbursed benefits and the actual financial requirements for providing the needed services, and place the provider in an untenable position. On the one hand, payments from the trust fund would fall short of the provider's cost, and on the other, the consumer could not be billed for the difference. The deficits that would be created for providers could only lead to a general reduction in service or to bankruptcy.

4. Another consequence of the system would be the inequity of imposing taxes for health insurance on individuals and on employers without relation to the number of beneficiaries covered, or to the actual untilization of services by the covered worker or his family. Under the typical trust fund proposal, a wage earner who is single would pay the same amount as a married coworker with

identical earnings and a large family, and the taxes they pay would bear little direct relationship to the insurance value they receive.

5. Some have argued that the federal system approach would remove a disincentive for employment of the physically handicapped. In point of fact, in the kind of group insurance that would result from the mandated purchase of insurance at a worker's place of employment, the cost of including coverage for the physically handicapped would be extremely low, and would not, as has been alleged, discourage employers from hiring the handicapped.

As a final point, proponents of the federal trust fund approach argue that it is the only way to assure that all persons would have access to the same level of comprehensive benefits. However, H.R. 1 would accomplish this same objective without creating the inflexibility of a single mechanism for collection and allocation of the health care dollars. We believe universality of coverage for all persons, irrespective of income level, age, or any other such variable, would be made possible by:

Mandating or placing a strong financial incentive for the availability of health insurance benefits for the employed;

Extending these benefits to persons who become unemployed;

Providing statewide pools for group insurance, available to the self-employed, small groups, and uninsurables;

Providing coverage for low-income persons financed through governmental general tax revenues, primarily federal; and

Continuing the existing Social Security tax mechanism for the aged and disabled.

For emphasis, we would reiterate that while funds for coverage of various segments of the population will come from different sources the benefits would be available to all persons. Continuity of benefits would also be assured. Thus, it is erroneous to assume that a trust fund is the only mechanism that can achieve the important objective of universal, comprehensive coverage.

Philanthropy

Philanthropy has been and continues to be a very important factor in the financing of health care services. Consider the following:[2]

Between 1964 and 1974, annual charitable giving for health increased from $1.98 billion to $3.90 billion.

This increase of over 200 percent is greater than that received by religious or educational recipients.

Charitable giving paid for some 4 percent of the nation's total health expenditures in 1974.

Philanthropy provided almost 10 percent of the funds used in 1973 for construction of private, nonprofit hospitals and other health facilities.

Philanthropy provided $220,000,000 for medical research in 1974.

These facts demonstrate the importance of philanthropy to the financing of health care and medical research in the past and suggest the calamitous impact that would result if such philanthropy were to be reduced or eliminated in the future.

The AHA believes specific provisions should be included in national health insurance legislation to protect and encourage private philanthropy for health care under national health insurance. H.R. 1 seeks to do this by language in the "Findings and Declaration of Purpose" section of the bill and by providing that institutions would not be required to use unrestricted gifts, grants, and income from endowments for ongoing operational expenditures. Of course, the bill does provide that philanthropic funds which are to be used for capital purposes would be subject to the certification of need process in the same manner as other capital expenditures. This last provision is designed to assure that philanthropic funds will not be used for non-approved facilities or services, but like all other resources development funds, will be subject to the health planning process and certificate of need laws.

Financial requirements

Because health care institutions are located in and serve every conceivable kind of community, and because such institutions themselves differ in size, scope, and the types of services they provide, their financial requirements vary. So does their ability to provide uncompensated services for nonpaying patients. Collections by health care institutions from all payors must yield sufficient revenues to meet the institution's full financial requirements. Our Association defines these requirements as the monetary resources a health care institution must have to fulfill its responsibilities in meeting its community's health service needs.

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[2] Source: 1. *Giving USA,* 1974 Annual Report, American Association of Fund Raising Counsel, Inc.; 2. *Hospitals, J.A.H.A.,* July 1, 1974.

We believe firmly that any national health insurance bill must spell out the elements of financial requirements for health care institutions in some detail. We strongly recommend that language be included in any NHI bill that is developed to adequately define institutional financial requirements. Suggested language is as follows:

The method or methods to be used, and the elements to be considered, in determining the financial requirements of hospitals and other health care institutions shall be prescribed by regulations and shall include—

1. requirements for direct and indirect expenses for patient care services, including such services to indigents with respect to whom payment by or for the patient is waived in whole or in part by the corporation or institution, but reduced by the amount of any grants (including income from endowments) earmarked by the donor or reserved by the governing body of the corporation or institution for payment for such services;
2. requirements to defray any deficit of approved education or training programs;
3. requirements for minor remodeling of facilities;
4. requirements for current operating needs (working capital) or to meet contingencies;
5. requirements for allowable interest on funds borrowed;
6. requirements to meet other operating expenses required to meet standards imposed under this Act, such as patient education programs;
7. requirements of specific price level depreciation to establish and perpetuate a revolving fund to meet ongoing expenditures for the purchase of major movable equipment;
8. requirements of general price level depreciation on other plant and equipment facilities for the maintenance and preservation of the corporation's or institution's assets;
9. requirements for prospective accumulation of funds or current payments for construction, replacements, major modernization, or expansion of plant, equipment, and services, approved by the planning process, and debt amortization of these projects in those years when the expenditures for those projects exceed the sum of depreciation payments under items 7 and 8 provided that the corporation or institutions makes assurance to the state health commission (as provided in H.R. 1) that the total payments for these financial requirements over the life of the facilities will not exceed their general price level depreciation charges;
10. requirements for a return on total assets employed in the provision of institutional health services with the Secretary of HEW determining annually a reasonable rate of return and with such rate for an institution being no less than the interest rate paid by the institution on its debt capital;
11. requirements needed to provide a margin of safety before the institution is paid on a prospective rate basis and in any given period there is a risk that the prospective rate will yield revenues that are below costs so that a reserve to meet such a contingency is necessary.

Payment of providers of service

Throughout the nation, institutional health care providers are being paid for their services under a variety of systems, ranging from retrospective cost-based reimbursement to prospective payment systems. Some of the prospective approaches are quite new and are still being evaluated. The Department of HEW reported that as of March 1974 there were 26 prospective payment systems in existence in 22 states, involving approximately 25 percent of the nation's hospitals. As indicated in the following table, HEW's report identifies three general categories of prospective systems, each of which may use any of four general bases for determining reasonableness of rates and any of four different units of payment.

Summary of rate-setting methodology of developed prospective rate systems[1]

	Number of programs
System basis:	
Budget approval	11
Charge increase review	11
Formula	4
Basis for determining reasonableness:	
Institutional comparison	14
Cost history only	10
Formula	2
Normative standards only	0
Unit of payments:	
Charges	15
Per diem	6
Budget allocation	3
Per admission	1
Experiment testing several methods	1

[1] Source: "Analysis of State and Regional Health Regulations." Health Resources Administration, Department of Health, Education, and Welfare. DHEW Publication No. (HRA) 75–611.

The American Hospital Association favors use of the prospective payment mechanism under national health insurance. On the other hand, because of the variety of approaches available within this "prospective" label, and because of the relative newness of these approaches, it appears premature to mandate in any national health insurance law the use of a single specific method of prospective payment to institutional providers of services. Therefore, it is our view that any national health insurance program should provide for the establishment, after consultation with hospitals and others, of one or more payment methods within each state. Payment methods that are to be developed on a state-by-state basis, in accordance with regulations of the Secretary, could be based on budget review, target rates, negotiation with third parties, formula or other appropriate methods. States should be permitted to develop more than one system and, where this occurs, providers should have the option of selecting from the alternatives. Once a system or systems were established in a state, they would apply uniformly to all payors, including the federal government.

Inherent in any prospective payment system is the possibility that estimates of volume may not be realized and that estimates of cost trends may be exceeded. It is essential that the service continuity of hospitals not be jeopardized by unpredicted changes in utilization, revenues, or costs. A reasonable operating margin will be necessary to provide flexibility to meet such potential developments and to help avoid recourse to alternate high-cost capital such as short-term borrowing. It also would offer a source for equity funds for improvement of services, subject, of course, to planning approval.

REGULATION

The Federal role

The federal government must play a pivotal role in any national health insurance program, with efforts directed toward (1) determining the basic level of health benefits that should be available for all, and how these benefits may progressively be expanded as the system grows and (2) establishing the scope, standards of quality, and comprehensiveness of health services. Although we believe that control mechanisms are best implemented at the state level rather than federally, the federal government should assure that the responsibilities and administrative structures of state agencies provide a reasonably uniform operation of the regulatory processes throughout the country. The federal government should also develop ways to coordinate the activities of all of its departments and agencies that are concerned with health and health-related programs, as well as those of voluntary organizations with respect to their conduct of approval, accreditation, or certification programs. To this end the American Hospital Association recommends establishment of a separate, cabinet-level Department of Health, with full responsibility for the implementation and coordination of a national health insurance program. It would be aided by a top-level advisory committee made up of consumers and providers.

The health care field is subject to an overabundance of controls, guidelines, audits, surveys, inspections and regulatory programs originating at all levels of government—federal, state, and local. Hospitals, especially, are faced with a myriad of regulatory programs and only on rare occasions are these regulatory activities effectively coordinated. National health insurance could provide an opportunity for the nation to make some sense of the multitude of overlapping efforts. In fact we believe that the development of an appropriate regulatory framework is an essential component of a national health insurance program.

The AHA's *Policy Statement* includes an effective framework for regulation of health service. That framework would provide for a balanced process in which the federal government would act as a catalyst for instituting necessary changes and as a monitor of their results.

State regulation

Under appropriate federal guidelines, review of provider rates, certification of need and planning activities, utilization controls, and controls over insurance premiums and benefits would be focused at the state and local levels. Such state and local control is essential in order to appropriately reflect social and economic variations from community to community and among the states across the country.

We believe that through the delegation of regulatory functions to state and local agencies a process can be developed that would be more truly responsive to the real needs within each community. Extensive, complex federal controls would be inflexible and inadequate in view of the diverse and highly varied nature of communities in different parts of the country and the ways in which they choose to meet their health care needs. What works well in a densely populated urban area won't always work well in a small town located in a rural area.

Competition on a controlled basis should be built into the system to maintain the system's viability, to stimulate efficiency and preserve the independence so vital to innovation, and to assure that local preference and precedence will be protected.

A trend toward state and local mechanisms for the regulation of health services has already surfaced. Legislation to establish a certificate-of-need process has been enacted in 27 states and currently is under consideration in several others. Prospective rate review processes also are in effect or under consideration in a number of states. As you know, P.L. 93–641, the National Health Planning and Resources Development Act to which you and your Committee contributed so much, calls for implementation of certificate of need programs in every state, authorizes experimentation in state rate review and regulation in six states, and emphasizes the responsibilities and role of state and local agencies or organizations in the planning and development of health resources.

Another example of delegaton of regulatory authority to state and local levels under federal guidelines is the establishment of Professional Standards Review Organizations (PSROs). Many other aspects of health care regulation and administration are already established at the state level, for example, licensing, facility standards, and carrier regulation. We feel that such regulatory activities in the health field can be carried out more effectively at state and local levels than at the federal level and that any national health insurance legislation should focus regulatory activities at the state and local levels under federal guidelines.

IMPLEMENTATION OF NATIONAL HEALTH INSURANCE

It is unreasonable to expect that a new or significantly changed health care delivery system can be brought into being immediately upon the enactment of legislation. Implementation of a national health insurance program which addresses itself to the goal of providing comprehensive health care to all Americans will be a tremenodus and complex task. It is in our view essential that any national health insurance legislation include a phasing-in stage which provides for the development of organizational and professional resources needed to meet this goal. For example, the bill could provide support for development of needed health care facilities and services, including new delivery organizations and outpatient centers, to begin immediately after the bill's enactment. As adequate resources are developed and as a restructuring of the delivery system takes place in the early years of the program, benefits could be phased-in, both in scope and in application to various population groups. At the same time, the development of new state-based regulatory systems could proceed so that all of these forces could converge after a reasonable period of say five years for the full implementation of the program.

CONCLUSION

In conclusion, Mr. Chairman, the American Hospital Association believes that our recommendations for dealing with the key issues involved offer reasonable and workable solutions to the problems of health care delivery, financing and regulation, and constitute a program that would meet the nation's health care needs. We strongly support and commend to the Committee the approach of H.R. 1, which provides for comprehensive health benefits for all Americans; for restructuring of the health care delivery system; for an equitable and adequate financing system and regulatory system to be implemented at state level; and for a necessary phase-in period.

We appreciate the opportunity to present our views on national health insurance and stand ready to assist the Committee further in any way we can.

SUMMARY[1] OF PRINCIPLES FOR A NATIONAL HEALTH INSURANCE PROGRAM

Approved by American Hospital Association February 1, 1975

General

A national health insurance program should tie together in an integrated and coordinated fashion all key elements in the health care system—including the health delivery system, the financing mechanisms, and the regulatory and administrative mechanisms.

The program should mandate a comprehensive benefits package, including catastrophic health benefits, to be available to all persons, financed through a variety of sources.

The program should allow sufficient time between enactment of legislation and the actual implementation of its provisions to ensure that adequate delivery systems resources and regulatory structures will be in place.

Health delivery system

The program should ensure access to health care for all persons and should ensure that the comprehensive benefits of the program are provided to beneficiaries. Such access and availability could be ensured by the development of community-based Health Care Corporations, organizations with the capacity and responsibility to provide comprehensive health care to a population group in a defined geographic area.

The program should ensure good quality care. The achievement of quality within the institution should be through utilization review and medical audit performed at the institutional level in a process that places primary responsibility on members of the medical profession who practice in the institution as members of organized institutional medical staffs.

The program should utilize privately developed and operated organizations such as the Joint Commission on Accreditation of Hospitals in determining the institutional and professional providers eligible to participate in the program.

Role of Government

There should be a balanced regulatory mechanism coordinating the roles of both federal and state governments.

The federal government's role should be one of coordinating the program through establishment of broad federal standards and guidelines which should be implemented at the state level, including state prospective rate review and certification of need processes.

A sound comprehensive health planning process at the local and state levels should be incorporated into the program. The basic planning process should be separate from the regulatory process, but should serve as a basis for certification of need decisions in the program.

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[1] Based on established AHA policy including the Policy Statement on Provision of Health Services, the Statement on the Financial Requirements of Health Care Institutions and Services, the Policy on the Implementation of the Statement on Financial Requirements, and other related AHA policies and guidelines.

There should be advisory councils at the federal and state levels with adequate provider representation.

Financing

There should be a pluralistic system of financing health services, using a variety of sources to support a comprehensive level of benefits for all persons. Employers on a cost-sharing basis with employees should be mandated to provide comprehensive health benefits to all employees. Self-employed persons and others should also have access to group insurance coverage. The payroll tax mechanism should not be expanded to finance health benefits.

The program should ensure that philanthropic assistance to the health care field is both maintained and encouraged.

Payments to institutional providers should be based on rates that are prospectively established to reflect total financial requirements. The program should specify the elements of financial requirements including an adequate recognition of the need for institutions to maintain an operating margin.

Blue Cross and Blue Shield plans and private insurance carriers should continue to play a role in underwriting employer/employee contracts, as well as other administrative roles for governmental programs.

There should be federal financial support and incentives to states for their new roles and to organizations forming community-based comprehensive delivery systems.

Every person if able should contribute to the cost of his health care, but no person should be denied access to health care because of inability to pay, and no person should be made financially destitute because of illness.

Mr. ROGERS. Thank you very much, Mr. McMahon, for an excellent statement.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I certainly think this has been a very comprehensive and an excellent statement.

How would the system of health care corporations relate to the health system agencies of the new planning legislation?

Mr. McMAHON. Dr. Carter, they address themselves to two different areas. One is a planning mechanism with certain developmental responsibilities, as you know, because the bill was developed in this committee, whereas the health care corporation itself is a delivery of services organization.

Now obviously it would be the responsibility of the health system agency to identify within its areas the need for a delivery mechanism, identifying geographic areas, for example, where the access to service wasn't adequate, and then to encourage or to require a health care corporation to develop its services in the underserved area, and reach out and then deliver the services that the health systems agency concluded was necessary or was in inadequate supply.

Mr. CARTER. Who would regulate the health care corporations?

Mr. McMAHON. The bill provides that State health commissions working under a Federal Health Commission setting forth broad policies would do it and, of course, would look at or have regulation over the providers of care that weren't in a health care corporation itself.

We do not envision that all institutions and all physicians would be shoved into the health care corporation against their will. It is only when they decided that their professional practice was appropriately handled that they would join in the organization of such a concept.

So, side by side, with the HCC's would exist the fee-for-services system, probably reaching out to meet some of the unmet needs, but under the regulatory authority of the State health commission.

Mr. CARTER. Physicians would not receive fees for services in this system?

Mr. McMAHON. In the health care corporation, Dr. Carter, they might either receive fees for services or a salary as they themselves in creating the health care corporation might desire.

In addition to that, of course, we envision, just as I believe you all did in the development of the health maintenance organization concept, that this would be one mechanism that for the time being would serve a number of people, but that the existing fee-for-service system and those who find professional satisfaction in it would clearly continue in that area.

Mr. CARTER. How would the health care corporation be constituted?

Mr. McMAHON. The providers of care in a particular geographic area would themselves constitute it. Just the way private individuals today set up corporations to achieve certain ends, that can't be done except in the corporate structure, and they decide the area to be served, how the various providers, physicians and the institutions would provide for their services, and then—subject to the rate approval of the State health care commission—what they would charge for the services either on a capitation or premium payment basis.

Mr. CARTER. What would your consumer representation be, or would you have any on this?

Mr. McMAHON. I don't see, other than the way hospitals have gone about providing representation from the patient areas they serve, that there would necessarily be, should be, a requirement for a specific kind of consumer participation.

All of us, I suppose, Dr. Carter, are consumers in that we need health care services, and it seems that we don't need additional regulation in this area. We have consumer involvement in the planning structure, but when it comes to developing a corporation to deliver services, it seems to me that the providers of care ought to be the governing board of such an organization.

Mr. CARTER. You would compete with HMO's, is that correct?

Mr. McMAHON. The health care corporation would, because of its geographic responsibility, Dr. Carter, have a different kind of role. I would imagine that many HMO's would seek a geographical, territorial allocation of responsibility and thus become health care corporations because, except for the geographic assignment of responsibility, they have got all of the other attributes of the HMO.

Obviously, if an HMO doesn't want to take on the geographic responsibility, then there would be competition.

Mr. CARTER. One question, Mr. Chairman. What preventive services does your plan include?

Mr. McMAHON. It covers a wide variety of preventive services, Dr. Carter, across the board, physical examinations including immunizations and to eye examinations to dental examinations, all without copayment, all with the time limits; in other words, we would have a mechanism for early identification of problems, so that the health delivery system could set about dealing with the problems uncovered.

Mr. CARTER. Thank you so much.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

I welcome my old law school colleague here, and a gentleman who has made a real contribution in the health field and a lot of others in North Carolina before he achieved his present eminence.

Mr. McMahon. Thank you, Mr. Preyer.

Mr. Preyer. Just following up on Dr. Carter's HMO question, the health care corporation seems to be somewhat similar in concept. Would your approach be workable if HMO's were substituted for health care corporations? Are they that similar?

Mr. McMahon. Mr. Preyer, I think that the only difference is that assignment of geographical responsibility as I indicated in response to a question from Dr. Carter. It is my guess that many of the health maintenance organizations would become health care corporations because they would accept the geographic assignment of responsibility.

On the other hand, there are some health maintenance-type organizations, perhaps like the Kaiser plans on the west coast, that are more identified with employer groups and might not want to take on the geographic responsibility.

Now, the whole key to the health care corporation concept is that geographic responsibility, so that after the concept, under the direction of the State health care commission, becomes mature, every individual would have an opportunity to sign up with a comprehensive delivery organization, and that would make the difference.

I think a health maintenance organization without that geographic responsibility would not achieve the solution to the problem of access to care that lay at the basis of our development of the concept.

Mr. Preyer. In view of our difficulties, our experience with implementing the PSRO and planning programs and HMO, do you think realistically we could develop and put into place health care corporations throughout our medical system?

Mr. McMahon. It may be, Mr. Preyer, that in the fall of 1975 that we are more preoccupied with the problems of getting health systems agencies going and the problems of getting professional standards review organizations set up, some of the inherent problems that I think Dr. Carter had in mind when he responded to a question when he was testifying, that we are not sure how precisely they are going to work. I think through all of this, maybe not by the precise PSRO mechanism we have, we are going to develop appropriate utilization review mechanisms. certainly as we see it, and I am sure the members of our hospital medical staff see it, with heavy emphasis on the activity in the hospital setting, certainly we are going to develop health systems agencies to do the planning.

I think with those things in place, we will discover that the health provider system is more malleable than sometimes it looks, and it is realistic to begin more and more to see this as certainly a way that we can reach underserved people that all of us in the provider world understand exist.

I see activities regularly as I travel the country and visit hospitals, such as the governing board and the administration and medical staff beginning to identify areas that aren't served and finding out how they can reach out and provide health services to those people.

This is just one step, a little more highly organized, but one step beyond what is going on at the present time. Yes, I believe it is realistic.

Mr. PREYER. You mentioned health care corporations as having a sort of geographic franchise, as I understand it. You also talked about them competing for enrollment. Are these two things consistent?

Mr. McMAHON. They are consistent, as we see it, in this way: That more and more there are providers of care, not only physicians but institutions as well, that find their professional satisfactions more in a system than as an individual physician on a one-to-one basis or a community hospital without a relationship with a medical center somewhere close by to which the most seriously ill and injured patients can be transferred.

The time is ripe, as we see it, for the develpment of this kind of concept, but obviously there are a lote of hospitals with their own directions and their own corporate goals and objectives that aren't consistent with that kind of system, and certainly there are lots of physicians that don't want to exist in a system like that.

So, we would see that the health care corporation would be there to provide for those people who are not satisfied with the existing fee-for-service system. But, just as we discovered when HMO's were created in a particular area, there is no great rush to knock down the doors and enroll in them.

There are some people that do sign up, but there are many who prefer to be served by the physician who has taken care of them for years in the institutions to which those physicians relate.

So, we see this as an evolutionary process providing for people a dual choice, if you like, very consistent with the goals and objectives this subcommittee had in mind, as I see it, in the devolopment of HMO activities.

Mr. PREYER. Thank you. That is a very thoughtful statement you have here.

Mr. ROGERS. Mr. Scheuer?

Mr. SCHEUER. I wish to welcome the witness. He is a very distinguished and learned leader in the hospital profession, and I have enjoyed your testimony very much.

I would like to ask you first a question about New York City.

We have something like 16 hospitals and perhaps 10,000 empty beds. How would your systematic approach affect the closing down of some of those hospitals with most, if not all, of those vacant beds?

Mr. McMAHON. It does not deal directly with that issue Mr. Scheuer, because we think that it will be dealt with by the planning structure, perhaps along with some regulations, as we learn a little more about the impact of regulations on hospitals, as for example, the lack of payment, of capital costs for facilities built without regard to the planning activity, and so on.

The difficulty with the situation in New York, as in some other communities in this country, is that we now have a problem because people's habits and patterns have changed. A time ago, when some of these empty beds were constructed, we thought first the population was going to continue to grow and, second, that the growth curve of hospital per-day utilization per thousand people was going to continue to grow.

We thought that the birthrate was going to continue an upward course. Now we find that that isn't the case. This activity does not deal directly with that problem. Frankly, I don't know yet how to deal with it, though obviously because it is a matter of great concern, we are giving some attention to it. Some discussions are going on in the Ways and Means and Senate Finance Committees as to how the medicaid-medicare reimbursement mechanism might be used, and we are participating in those, but that is a somewhat separate problem, frankly.

Mr. Scheuer. On page 5 you are somewhat critical of the approach of deductibles and high copayments as a means of creating incentives to avert overstress of the system, and you remark on the first line of page 4 that these deductibles and high copayments are not of very much use since much of the medicare use is not determined by the patient, and then you talk about properly constructed utilization reviews.

Mr. McMahon. Yes, sir.

Mr. Scheuer. I don't know of anywhere where the profession itself has turned a very successful hand toward educating doctors to do something about overuse, unnecessary hospitalization, unnecessary prescription of drugs, unnecessary surgery and the like.

My question to you is, what makes this——

Mr. McMahon. I guess we start from a different set of assumptions. If you start from a different set of assumptions, Mr. Scheuer, you pretty quickly get to a different set of conclusions. I think the activities of the American Medical Association, in its peer review activities, through the structure of organized medicine, beginning with the county medical societies for problems that exist, speak for physician recognition of the necessity for utilization review and medical audit within the institution. After all, the AMA and AHA and College of Physicians and Surgeons through the Joint Commission on Accreditation of Hospitals have long said a properly run institution has a structure for examining the kind of medicine that is practiced, of using standards, evaluation of care against those standards, and finally, an educational process along with it.

We have all recognized this has to come about. It is a very slow process, but my assumption is, in the first place, there is broad recognition that this kind of activity is most appropriate, and little by little we are growing in the direction of looking at it.

I don't accept the fact that there is a tremendous amount of unnecessary surgery. What is unnecessary surgery? We don't have yet an outcome measure by which we can say that this much is wrong. We know more takes place in some places than in others.

But, we don't yet know how to relate the difference in activity through an outcome measure to the health of the people involved. So, I think by focusing attention on what is going wrong, or learning how we can use the educational process rather than the policing process, to identify and then through education correct inappropriate practice habits, and we all agree that they are there, not to any large extent, but enough so that to be accountable we ought to focus on it, that we are making steady progress and can make more in the area I have identified.

Mr. Scheuer. Is there any evidence we are making steady progress? Could you supply us with any evidence that we are making progress in the business of educating doctors not to just give the patient everything, largely involving the practice of defensive medicine, but where is education going on to cut down unnecessary hospitalization?

Victor Fuchs, whom I am sure you are familiar with——

Mr. McMahon. I am.

Mr. Scheuer [continuing]. Documented that in certain east coast hospitals, the average hospital stay for a heart attack was on the order of 3 weeks, and in one of the HMO's on the west coast it was less than a week, with absolutely no identifiable difference in health outcome.

As you mentioned in the next paragraph in that kind of illness in England, the patients are treated at home, with still no evidence that they had a better or a worse health outcome with virtually no hospitalization at all.

So, if you have any information on the progress that is taking place at the physician level, in terms of avoiding unnecessary hospitalization, and putting the patient at the ambulatory level of health services, or with home health care, where that is appropriate, for shortening the hospital stay, avoiding unnecessary surgery, and we have had numerous studies on unnecessary surgery.

ILGWU did a large study of thousands of operations on people. They came up with the figure approximately a quarter of those operations were unnecessary.

If you have any information as to what the medical profession is doing to educate its own to achieve some of these economies, I would be very grateful if you would supply it to us.

Mr. McMahon. We have no specific measurable outcome because we don't have an outcome measurement of any kind, but we do have an——

Mr. Scheuer. You have measurements of morbidity and mortality, of course you have.

Mr. McMahon. Of course, is is very difficult to take gross figures that are areawide in nature and relate them to a specific hospital. What we do know, however, and this is a matter that has come in for substantial discussion, in the Joint Commission on Accreditation of Hospitals, as the board of that Commission and its staff were trying to develop ways to relate general statistics to specific institutions or practices.

We know there is a tremendous increase in review activity and it is our feeling that once you put a process in place, once there is a committee that is setting up standards for the practice in the hospital, once there are medical care evaluation studies that are examining within that hospital the kinds of outcomes that are happening from the following of that process, we are convinced that that kind of activity is productive and that it will improve things.

But, until we can find a way to measure the patient population and its morbidity statistics against what happens in the hospital, we will be short of being able to say yes, this works or yes, that the benefit of this is related to the cost.

One of the problems that concerned me, for example, again in the case of one of the things you mentioned, the ILGWU study, is that if you have a consultation before each surgery, you are using up surgical manpower in the determination or in the consultation itself.

What happens to the patient if his doctor to whom he is related all of his life says you need surgery and the consultant says you don't?

Do you then get a third, and more and more manpower goes into that and what are we doing for the patients?

Mr. SCHEUER. Maybe it is an unnecessary operation for the patient.

Mr. MCMAHON. Who is to say it is unnecessary? Why is it that the consultant is automatically more knowledgeable than the surgeon who has been taking care of that patient for a long period of time?

Mr. SCHEUER. If it is a fee-for-service basis, consciously or unconsciously, that doctor might be under some kind of pressure to exercise his professional services and receive a check in the mail. Does that idea shock you or horrify you?

Mr. MCMAHON. No, it is an allegation that I can't support in my own experience because I do not know of physicians who are motivated that way. Admittedly, there are some, but it is a handful.

Mr. SCHEUER. How do you explain the result of the ILGWU study?

Mr. MCMAHON. Oh, I don't know how I explain it. I think it is one of those things where a small sample has been blown up into a situation and extrapolated to the point where we have gone from some unwarranted assumptions to some foregone conclusions, but I think there are lots of other things that we don't know about.

We know some gross figures. We do not know what the effect of a denial of surgery was. We don't know, for example, that when the administrators of that trust fund who made the determination they weren't going to pay for something that it didn't happen anyhow because the individual may have gone out and said it is important enough to me and my doctor so I am going to have it done.

Mr. SCHEUER. I am not convinced. I avoided unnecessary surgery once, and I have gotten along as happy as a clam since, and I will give you the details right now.

I was at the Warm Spring Foundation in 1948, and I went there flared, if you know what that means. The time came for me to learn to walk, and I couldn't lift my left foot and they wanted to do a paraneural transplant. You know what that is, the surgeon wanted to do a paraneural transplant.

The young intern who was in charge of me got me in a corner and said:

> Don't do it, you will get along okay. Instead of a paraneural transplant, you think about lifting your big toe. After you do that, that foot will come up. Don't think about raising your foot. You don't have muscles to raise the foot.

That is exactly what happened, and I never had a paraneural transplant, and I get along as happy as a clam just thinking toe instead of foot.

Mr. MCMAHON. That is an excellent example. It is why, Mr. Scheuer, that we say that medicine is an art and not a science. We just don't know, things work like that, but the reverse also happens.

Right now I think we focus on the examples like that without focusing on the individual who because he decided for fear, for economic reasons, or for some other reasons, to forego an operation, ended up far worse off than he would have been.

Mr. SCHEUER. It is my understanding that as far as back in 1911 Professor Cardman at Harvard Medical School followed patients through after surgery in his hospital and checked their health outcomes as a way of assessing both the quality of the operation and the post-operative care and the necessity for it.

If we could do that over half a century ago, how is it was don't have objective criteria of health outcomes now for hospital treatment, as well as operations?

Mr. McMahon. I guess because we don't know what health is. We don't know what a healthy individual is because different kinds of people have different kinds of standards of their own.

You mentioned that study in England that indicated that an individual, after the first—I have forgotten what it was—3 or 4 hours—perhaps Dr. Carter remembers—that if you get by that time you had as much chance of recovering at home if you had a wife or resident mistress as you did in the hospital. I guess in the English system they had to add that additional qualifier.

That isn't acceptable to people in this country. That is not what they are used to. They want the cardiac care units and intensive care units, and we are going to see this in the health system agency operation, that much of the overconstruction and duplication of services isn't generated by doctors in hospitals, it is because the people that relate to those doctors and to those institutions want that kind of service for doctors and institutions to which they relate.

That is the reason I say the financial mechanism is so very important to all of this that if they want it, if people in the District of Columbia want more EMI scanners or want a different level of services, we had better figure out a system that will let them—through their health insurance premiums or some other financial mechanism—participate in the payment, then we will have a better system by which people in one area can go one way and pay for it and people in another area have a different level, and then by evaluating the two we are going to learn a lot more than if we try a uniform system at a time we don't have all the answers.

Mr. Scheuer. On page 8 you talk about the need for providing outpatient and ambulatory care services. Now, as I know you are very well aware, because you helped instruct me in this matter not long ago, the present funding mechanism has a tendency to force people into hospitals, who could be treated on an ambulatory and outpatient basis or could very well be taken care of through home health care. They have no formula for reimbursing hospitals adequately for ambulatory care and no home care formula at all. They are put into hospital beds. Instead of providing many medicare patients on an ambulatory care basis or some kind of simple home care, we are providing them with simple 24-hour hotel service.

How would your bill provide different incentives against forcing people out of the most expensive level of the medical services heirarchy, so to speak, a level of sophistication of services grossly out of proportion to what they need, and how do we provide incentives for getting them in at the lowest level of cost and sophistication that is appropriate and relevant for whatever their illness may be?

Mr. McMahon. I can answer——

Mr. Scheuer. Third, answer this question for me: How do we get back to the old point of view where if you had a terminal illness you felt satisfied and confortable to die at home rather than feeling you must die in an institution with all kinds of tubes and specialists and whatnot?

When I was a kid, people at some point in the lives expected to die at home. When there was nothing more the medical profession could do for them, it was the thing to die at home, and not only were they happy and more secure with their friends and relatives around them, but it saved society a great deal of money.

How do we get people who need care into the system at the lowest level of care necessary, and when they are beyond the point at which care can help them—how do we create an environment where they feel proper and right to die at home?

Mr. McMahon. By providing coverage for the alternative, by utilization review to make sure that the patient is treated appropriately. I think again we are on a problem of assumptions, I don't think people have lost the desire to die at home. I think that is what they want. I think that if we can get by the overexpectation, that if they go into the hospital they are going to live instead of die, as it used to be, we will get a balance back.

Mr. Scheuer. Thank you very much.

Mr. Carter. A point of order. According to the way I look at it, the gentleman has consumed approximately 30 minutes. Time was called on me at 5 minutes, and I had asked only three of the six questions I had.

I really can't conceive of why regular order is departed from in such a case as this.

Mr. Scheuer. Mr. Chairman, I ask unanimous consent that the gentleman be given time to ask his two questions.

Mr. Rogers. I think the gentleman from New York did go over his time. I called time, and he asked for an additional question. He started at 3:39.

Mr. Carter. Then I was wrong by about 10 minutes.

Mr. Rogers. But you are right, he was over his time.

Mr. Carter. I would hope that if we are going to have regular procedure, it is just a little bit embarrassing to always be cut short.

Mr. Rogers. I agree. However, I also let the gentleman have 10 minutes, according to my records.

Mr. Carter. According to your records. I am sorry that you have let me have the extra 5.

Mr. Rogers. The gentleman asked me to let him have another question, too, as I recall.

I agree with the gentlemen. We should try to adhere to our schedule.

Mr. Scheuer. A parliamentary inquiry. Instead of this colloguy, if the gentleman had asked his two questions, wouldn't they be finished by now?

Mr. Rogers. It is well to discuss this, I think.

Mr. Carter. You know we have been listening to a diatribe against physicians, and it happens that I am one. As you may know, it is very difficult to become a physician. I remind most of the people here in this group that one day in their lives they are going to want to see a physician, and I point to a saying which I have mentioned before, and it goes like this: "On the brink of danger, and not before, God and the doctor you adore. When the danger is over and all is rigthed, God is forgotten and the doctor, slighted."

Mr. Scheuer. I withdraw my unanimous-consent request.

Mr. Carter. I want to proceed a little bit further.

In every group, no matter what it is, there are those people who do not obey the rules or precepts of that particular profession. It is said that we may have a few lawyers of ill repute. It is even said that we might have a few landlords of ill repute, that renters sometimes are overcharged or given very poor accommodations. I think that only applies to about 3 percent of our people.

Now, another thing. I am not at home at all times. As it happens, my two parents died at home—my mother in my arms. My father-in-law died in his home. My mother-in-law is 91 years old, and by the grace of God I trust that she will be permitted to die at home, where she wants to.

But, at the same time, home care can't take the place of people who are really sick. You have no place there to do your analysis, complete blood count, blood sugar, and electrocardiogram, or bone marrow.

These are things which people demand when they really become ill and which they should be given. Of course, for a common cold or something of this nature, it might be all right to take care of them at home.

But, there are certain things that are necessary, and anyone who wants to go back to the 1900's and take the pulse, look at the tongue and prescribe for the liver, belongs to the ages past. He is not living in the future.

Thank you, Mr. Chairman.

Mr. Rogers. All right, let me ask a few questions now. I will try to make them short.

The effective date of your bill would be what? If we passed this bill in the next year, when would it become effective?

Mr. McMahon. It would begin July 1 or January 1 whichever first came within 6 months after enactment.

Mr. Rogers. On July 1. You feel we would be prepared to move into it within a 1-year period?

Mr. McMahon. The program is phased in, Mr. Chairman. It is phased in over a 5-year period. The requirement for all of the specified benefits become effective over a 5-year period of time so that the extension of the benefits from what an individual has is staggered on a year-to-year basis; in other words, so that the provider system can adequately then respond to the slight increase.

Mr. Rogers. What is done the first year, basically?

Mr. McMahon. In the first year to the third year benefits would include the medicare level of benefits, parts A and B, as the minimal level of coverage.

Mr. Rogers. All right, the second year.

Mr. McMahon. Rather than take the time, Mr. Chairman, can we submit the answers because while we have it here, the technical year-by-year thing might be better to submit for the record.

Mr. Rogers. The third and so on. I think that would be well to set that out in the testimony.

[See letter dated January 9, 1976, p. 194, this hearing.]

Mr. Rogers. What is the cost of your bill?

Mr. McMahon. The closest analysis that we have in that was a paper prepared by Health, Education, and Welfare on estimated health expenditures under selected national health insurance bills, and a table on that indicates that making certain assumptions about the personal health care expenditures, because the work was done in 1973, as to where things would be in 1975, on the basis that without a bill the expenditures, personal health care expenditures, would total $103 billion.

The Ullman bill, it was concluded, would add about $11 billion to the total expenditures, Mr. Chairman, when it became matured after the 5-year phase-in period. That it would be in that area because clearly a broadened benefit structure and providing of a uniform set of benefits for the poor and near poor, will increase the expenditures as well, of course, as the health services available.

Mr. Rogers. What would you say the cost would be to join a HCC for a family of four?

Mr. McMahon. I am not sure, Mr. Chairman, to what extent it will vary from the regular comprehensive physician and hospital coverage. We still don't know what the total expenditure difference is between the Health Maintenance Organization and a regular fee for services system.

There are a lot of assumptions that are made, but we don't know completely. My guess is that we are talking about a comprehensive program with a premium cost of perhaps $80 to $90 a month, $90 a month let's say in round figures.

I think the advantage that we saw in the beginning of having a dual system, one of a health care corporation that is available and one of the traditional fee for services system, is that we weren't thinking so much there would be a cost difference as there may be a choice in services difference, and people generally are more satisfied if they have an alternative rather than to have a specific system forced at them.

Mr. Rogers. Then there is no estimate yet as to what it would cost a family of four. Could you give us that statement for the record?

Mr. McMahon. Yes, $90 a month I think would come pretty close, but it is in here, we will provide that for the record.

Mr. Rogers. I think that would be helpful.

[See letter dated January 9, 1976, p. 194, this hearing.]

Mr. Rogers. How would the HCC's be formed? Would the hospitals come together and say we want to be an HCC or would they be required to do so; should they be recquired by law to be an HCC? What does the bill provide?

Mr. McMahon. Mr. Chairman, it provides, first, that providers of care may come together to form a health care corporation depending then on the number of institutions and the number of physicians, there would be some clear idea of what kind of geographic area they might be franchised to cover.

Mr. Rogers. They would be franchised?

Mr. McMahon. Yes, by the State Health Commission, in effect, that the State Health Commission would say to them yes, you have asked for the opportunity to cover this much of a city or a county or two counties. Yes, we will grant you the opportunity or grant you the opportunity to accept anybody within that area.

The place where the delicacy comes in is that in a sparsely populated area they might say we would like to have the responsibility for the two counties, nobody has applied for a third county, and the State

Health Commission might then say we will give you both counties if you will take a third one.

So, it is in the discussion that goes back and forth in the geographic area and the rate structure and other kinds of things that gives the State Health Commission a way to encourage these groups to move out into areas that are not served.

Mr. Rogers. So, the decision is made by the State health authorities?

Mr. McMahon. Yes, and there would be Federal grants in the health resources part of the bill that would be available to encourage them to——

Mr. Rogers. Is this done through the mechanism established through the health planning bill?

Mr. McMahon. Mr. Chairman, when H.R. 1 was introduced on January 14 and was in the process of discussion in December of a year ago, we didn't know what the situation would be with the new planning structure.

Mr. Ullman was quite well aware of that and recognizes that the Federal Health Department/State Health Commission structure must be rethought at some point to see whether it is now inconsistent, or redundant in part with the new health planning structure.

Mr. Rogers. Is Mr. Ullman still supporting this bill?

Mr. McMahon. He is indeed, but he recognizes that that detail may have to be changed in the process. I have had some people at work on this. Does the State Health Commission change in any way or should it be changed in any way in the light of the State health planning and development agencies?

Since they have the certificate of need, this bill might simply take out the certificate of need from the State Health Commission here, leaving it all of the other responsibilities. Or, by the same token, it might be better to transfer that over.

We are in the process of looking at that, and I can't tell you today what our recommendation would be to Mr. Ullman or to this committee if and when discussion comes to the point where you are actually looking at the specifics of it.

We intend to have a recommendation by that time, but I cannot tell you precisely today how we would go in some of the details of that, Mr. Chairman.

Mr. Rogers. I didn't know, because Mr. Ullman has not advised this committee of his interest in this bill.

Mr. McMahon. As instructor of it, I would have assumed that he thought the committee would take judicial notice of the fact of legislative notice, Mr. Chairman, of having introduced it that he would support it.

Mr. Rogers. People change, and when they don't appear to support their bills, it calls into question the continued support of the sponsor. You might discuss that with him.

Mr. McMahon. I should be glad to. I understand from him directly that he maintained the interest he had on January 14 in this bill.

Mr. Rogers. I think the committee would appreciate some expression from the sponsor, if he is still interested in this committee's consideration. I realize another committee considers this bill too, but this committee also has jurisdiction over it.

Mr. McMahon. We will have, Mr. Chairman, some specific suggestion if we could submit them at a later time——

Mr. Rogers. I think that would be helpful.

Mr. McMahon [continuing]. How this would tie into new planning structure.

[See letter dated January 9, 1976, p. 194, this hearing.]

Mr. Rogers. A health care corporation then would be determined by a State agency or perhaps through the planning process?

Mr. McMahon. Right.

Mr. Rogers. If it is brought to date?

Mr. McMahon. Yes.

Mr. Rogers. Suppose there are no HCC's in the area at all? Then what?

Mr. McMahon. Mr. Chairman, it is our feeling that through the certificate of need process there lies a sufficient disincentive to bring it about. Specifically, if a provider, an institution, were to come to the certificate of need granting agencies, saying we would like to expand, one might very easily envision the dialog that then takes place.

We will let you expand the facilities if you will take responsibility for providing care or creating a health care corporation that will then provide access to care to people in your immediate geographic area. I think that is the key way, along with the rate review itself, and the reason for providing a controlled locus of the certificate of need and rate review and utilization review in one agency, that would give it sufficient clout to encourage the extension of services in the underserved areas.

Mr. Rogers. But this is all prospective, so we don't know if that could be phased in in 5 years.

Mr. McMahon. It was our feeling that 5 years would be an appropriate period of time to guarantee then that through this process that the health care corporations would be in place to guarantee the services.

Mr. Rogers. I question that, unless there is some reason for them to form. What is the advantage for them to do it?

Mr. McMahon. The advantage is that forming an HCC overcomes the disadvantage of not getting the likely approval for the expansion of facilities and services, if they are not in the HCC process, if they are not in the process of doing it, and if an organization to which they don't relate is in the process of providing that.

Mr. Rogers. Your requirement for expansion of facilities would be that they must become an HCC?

Mr. McMahon. Not necessarily, Mr. Chairman. But that in the expansion, in the consideration of the expansion procedurally from the institution, very obviously one of the items to be considered by the certificate of need granting agency is, are there any people not now being served or without access to a health care corporation in your area.

Mr. Rogers. If there is any requirement, how could that be made a criteria?

Mr. McMahon. I would imagine that——

Mr. Rogers. Unless it is done in the law.

Mr. McMahon. It could be done in the law. In the law, this was left really to the regulators of the State Health Commission.

Mr. Rogers. In other words, do you see any objection to carrying out your plan if we should say that hospitals shall be HCC's within a 5-year period?

Mr. McMahon. I would think, yes, Mr. Chairman, there would be a problem with that because I'm not sure that in that period of time that we need to force every institution into a health care corporation.

Mr. Rogers. Say 80 percent?

Mr. McMahon. Why would it not be for the law, instead of leaving it to regulation, for the law, Mr. Chairman, if it were deemed appropriate to do so, to be amended to say that before any certificate of need is granted access to an HCC would be considered as a factor?

Mr. Rogers. They may never come back for a certificate of need if the hospital has just been built. They may not have to expand within 5 years. In fact, we are having overbedding, and as we get into more preventive and more outpatient care—as I am sure you support—we hope we will even reduce the number of beds.

Mr. McMahon. This goes beyond beds and includes the services.

Mr. Rogers. I understand.

Mr. McMahon. But they can get—you give them the choice. There are other availabilities in services, such as the physicians, such as clinics, group practices, and so forth. In other words, if the HCC is a good concept, why should it not be a part of the law?

Mr. Rogers. If it is not, then I don't know that we are making much progress.

Mr. McMahon. Mr. Chairman, two aspects to the response. The first one is that I don't think you need to mandate things that are done voluntarily. If done with encouragement, they are much more satisfactory than forcing the people into situations they may not find themselves comfortable with, particularly if something else is being done that meets the need.

Mr. Rogers. But then this is all being done now; I thought you proposed it to meet the need.

Mr. McMahon. I do indeed.

Mr. Rogers. You say on the one hand that it is not being met now, and yet now you tell me maybe the need is being met.

Mr. McMahon. Let me give you another specific piece of data. I can't be precise, but I have got the figures in the back of my mind.

In the State of Virginia, after the certificate——

Mr. Rogers. Excuse me, I am sorry. The second bells have rung for us to answer a quorum.

[Brief recess.]

Mr. Scheuer [presiding]. Following on Paul Rogers' questions, I am sort of dizzy trying to figure out the varying types of copayment and eligibility requirements at various levels of Government who are going to be doing things.

You have got HCC, you have got CHCB, SHC. It seems to me that is an administrative nightmare.

Mr. McMahon. Mr. Scheuer, you have a very, very complex system and very, very complex sets of problems to meet, and I know of no way to provide a simple solution to a complex problem. That is the reason for the complexity in all of this.

If there is a way to simplify it, I can assure you we would be the first to urge it, but we know of no way to simplify a vastly complex provider system, a financial system, and regulatory system.

Mr. Scheuer. Under your plan, who would be responsible for tracking, who was eligible for what, and who was going to pay for it?

It seems to me one of the problems we have in medicare and medicaid, and God knows what, is that there is no clear oversight. There is no clear vesting of responsibility of one source to monitor the whole system and I see this as sort of an administrative Rube Goldberg cartoon. Who is going to keep track of who is eligible for what kind of aid? Who will monitor the services and assure proper payments? Who would be in charge of this shop?

Mr. McMahon. In some ways, from the payment side, it isn't vastly different from the system that we have; that is, that the employers——

Mr. Scheuer. When you say that, you are damming with very faint praise.

Mr. McMahon. That may be, but sometimes progress is made gradually, building on the strength of what we have. That employer and the employees, employer and his employees, pool some money, 75 percent at least employer, 25 percent employees, to buy insurance, not unlike the present system.

Medicare is financed through the social security trust fund and the Federal Government through the system buys a comprehensive set of benefits and the Federal Government using general revenues buys a particular set of benefits for the poor as well. Now, the monitoring——

Mr. Scheuer. Let me ask you a question. Would your bill allow sale of supplemental health insurance against the cost-sharing cost required by your program?

Mr. McMahon. My recollection is that it would not prohibit because it provides a certain——

Mr. Scheuer. Wouldn't this tend to undercut the value of cost sharing, of controlling inappropriate use of facilities, overstress, and overutilization, in effect the whole business of waste that we have been talking about?

I might add if you don't like cost sharing, how much would premiums have to increase in its absence?

Mr. McMahon. As a practical matter, I misspoke, as I look at this, regardless of whether the individual has insured himself against the copayment he must at the time of the services pay whatever the copayment is.

If it is $2 of the attending physician fee, then he must pay at the time of service. So, he could not go beyond that. There are provisions in the bill itself that would avoid duplicate coverage; in other words, that there be a specific though modest payment at the time of the services, again checked through the health card and provisions to eliminate, because of the multiple employment situations we have, provision to identify the employer who would be responsible for each individual and each family and steps to eliminate the duplication that we sometimes have now.

You are familiar, of course, with the fact that some people who have several different insurance policies to cover certain health benefits may, as a matter of fact, make money on a hospitalized illness.

Mr. Scheuer. Perhaps that is why a good many people are hospitalized, because the hospital makes out better that way.

Mr. McMahon. I presume that is not the case because the hospital cannot admit the patient. Only a physician can admit the patient. It is not economically involved in that way.

While there are times when there are encouragements to physicians to admit people, I am certain with multiple insurance policies, his own professional judgment would not allow him to be influenced by that kind of economic consideration.

Mr. Scheuer. I introduced a letter into the record from the administrator of a hospital, addressed to all attending physicians, which said very nicely and elegantly that we want to maintain high levels of care, and that the only way we can do that is to keep our bed count high, So keep them coming in.

Let's go off the record for a moment.

[Discussion off the record.]

Mr. Scheuer. Do you propose reorganization of HEW with a health setup as a separate department?

Mr. McMahon. Yes.

Mr. Scheuer. Don't you worry about overfederalization of the program and big brother telling everybody what to do? I didn't think I was going to worry about that, but I have been to England, talking to the national health people there, and talking to individual doctors.

I have come to the conclusion that all the wisdom does not necessarily reside in Washington, and I am a little bit concerned about overcentralization of authority and decisionmaking, and giving too much power to the Federal Government.

This is not a partisan business because the same abuses happen under Democratic administrations as happen under Republican administrations.

Mr. McMahon. We are very much concerned about overcentralization, Mr. Scheuer. That is the reason why, as we indicated in the testimony, we have got a problem with the trust fund approach or the general tax revenues as the sole basis for the support of a national health insurance program.

We think by identifying the Federal role with a separate department of health, by identifying the Federal role as a directional role, as an overall umbrella role to provide direction, but basically through putting the regulatory responsibility in the State Health Commissions, and then by providing decentralization both through the employers' involvement, through health insurance for his employees, and for the development of comprehensive delivery organization, the Health Care Corporation, at the level where services are delivered, that we provide an appropriate balance that will prevent overcentralization in Washington, which gives us just as much concern as you have evidenced.

Mr. Scheuer. Your legislation relies on premiums for financing. Do those premiums vary with income, or are they simply flat premiums for everybody?

Mr. McMahon. They would be flat premiums at the outset, but individuals in the lower income levels, lower income level individuals would have a ceiling as to how much they would pay with the difference then being made up from the Federal Treasury, because they would then come under the definition of either poor or near poor, as the case may be.

Mr. Scheuer. Why wouldn't you rather have this financed through the general treasury——

Mr. McMahon. For two reasons.

Mr. Scheuer [continuing]. Which is a much more progressive way of financing a major Government program. It seems to me that the method you propose is a more regressive way in terms of tax equity, tax fairness.

It is far less satisfactory and far less just than simply financing this kind of program out of the general treasury.

Mr. McMahon. I guess we began by having some concern about the extent to which progressive taxation will work it. Our present tax system, both the Federal and the State income tax levels, is heavily progressive now. We weren't concerned, as much concerned, with this kind of financing at the outset in the light of heavy progressive income taxation.

On the other hand, there are more pros than that single con to it, the pro being that if you provide across-the-board progressive income tax and create a fund, and at the same time you want to have local decisionmaking as to the facilities and the services that are available, you are going to have the kind of situation that was described recently at a meeting here in Washington as the case of the six individuals who go to lunch and decide ahead of time they are going to split the bill six ways.

Where is the discipline? There isn't any. If you have a single Federal tax, you have got the same kind of problem then in the encouragement of the health systems agencies and the State organization to exercise some restraint.

If whatever they do it is going to come from the Federal Treasury and Federal trust fund, I don't see where the restraint is.

Mr. Scheuer. I thought you told me the doctors were going to provide that restraint.

Mr. McMahon. Thy provide some, but we have got to have everybody involved.

Mr. Scheuer. You don't like low premium and you don't like coinsurance.

Mr. McMahon. I didn't say that flatly. I said that a combination of cost sharing for the individual at the time of services, plus utilization review, is a better mix to provide constraint than either a heavy deductible or much higher coinsurance, as the only determinant.

Modest copayments, plus utilization review, will get the job done better. The difficulty, as I mentioned earlier, in making decisions about how many hospitals, how many beds, how many services, isn't solely the decision of the physicians and the hospitals.

We see evidence of this quite regularly in the hearings of certificate of need agencies. Very often the people that are most upset about a threat to the inability through a decision not to grant certificate of need, the people that are most upset are the patients who relate to that institution anyhow, and if we have nothing but a Federal dollar flow, I am suggesting that there isn't adequate restraint at the community level, that it is much better to tie together that decision and then through experience in community rating and other mechanisms to have the people, through their insurance, pay a premium rate that in effect will pay for this level of services that they provide.

That is really all an insurance or carrier mechanism in the health world is. It is a way you pool money to pay for the services that the covered people need.

Mr. Scheuer. And to the extent that you are asking low-income people to pay the same pooling charge as the high-income people, you have got a regressive system as compared to the basic Federal income tax, which through the General Treasury would provide a far more progressive way of paying for that.

Mr. McMahon. It is the lower-income—the low-income—people who will be subsidized. It gets up to not far from where Dr. Carter indicated his cut-off was, above $10,000 is the place. Absolutely, an individual making $12,000 under this scheme pays the same health insurance as an individual making $20,000.

Mr. Scheuer. Or $50,000?

Mr. McMahon. Or $50,000. But the offset to that, we think, is against the other kinds of taxes and charges these people pay and the total is not inappropriate.

Mr. Scheuer. Next question. It is my understanding that once you have just a very primative ifrastructure of health services, the main determinant of health outcomes, in terms of cost benefits, is not more health services and more doctors and more laboratories, but human behavior. I am referring to how people organize their lives and how they use the system that exists, particularly how they use the preventive health care elements, how they perceive of their own health needs in terms of exercise, diet, alcohol, drugs, and also their proclivity to involve themselves in accidents and violence.

If you look at the use of seatbelts, you get a clear message; perhaps not more than 20 percent of the people on the average use seatbelts. If instead of 20 percent, 75 percent used seatbelts, we would save something like 12.000 to 14,000 deaths a year and about $15 billion.

What can we do about human behavior? Where in the health system should we lodge responsibility for educating people to take the simple steps that they can take that will cost them nothing and, in many cases, will save them money, in order to have this major essential impact on health outcomes?

Mr. McMahon. You came to the question, where in the system do we begin? Doesn't this committee have a health education bill under consideration?

Mr. Scheuer. We do, indeed.

Mr. McMahon. Certainly, some attention can well be given to what we can do in terms of education.

There is a new National Center for Health Education just underway. We are supporting its efforts in every way we know to continue to explore ways in which education itself can bring about a modification of the lifestyle.

I have again some difficulty, I guess, Mr. Scheuer, with the assumption that after a very primitive level of health services, nothing else seems to have any effect.

Mr. Scheuer. I didn't say that. I said behavior has the dominant effect. Of course, as you add on services and facilities they help as well.

Mr. McMahon. It will have some effect on behavior itself. The health care system is made up of people who know how to take care of the sick and the injured. We don't have, nor do we claim to have, the skills to know how to change lifestyle. We are perfectly ready to enter into discussion on the basis of what we know from the observation of individuals, I think Dr. Carter would agree, to enter into discussions about——

Mr. Scheuer. It seems to me that on the question of cost effectiveness, the thing the health profession can do is to help well people stay well.

Mr. McMahon. I don't have any question about that. I don't know that getting people to buckle their seatbelts or to quit smoking is a matter that has ever been within the experience of health professionals.

Other things are. Clearly we are focusing in on those. For example, the individual who goes to the hospital for treatment of diabetes needs a lot of education in the kind of diet that he ought to have when he goes back home, and we are beginning to focus on that.

We have not done it in the past. This we call patient education as distinguished from consumer education, which deals with the question of seatbelts, things that aren't a health matter.

But, there is a tremendous amount of activity both in physician circles because basically these are medical decisions, but done in the hospital as well to focus on how we can educate people while they are sick or while a member of their family is sick to take better care of themselves to reduce the incidents of readmission.

So, there are some things that as health professionals we are doing to bring about attention to the modification of behavior that can be helpful, but there are other areas that we think are beyond what we can do to change the lifestyle, for example.

Mr. Scheuer. I have been talking about efforts you might undertake to produce that change in lifestyle through counseling in the hospital.

Would your bill include reimbursement?

Mr. McMahon. Yes; it certainly would, and encourages health educational activity, particularly on the patient education side. There are cases where hospitals as institutions have gotten involved in community educational programs. There have been no questions raised about that, when it is a sound program, and soundly conceived.

Mr. Scheuer. Dr. Carter?

Mr. McMahon. There has been no question about that.

Mr. Carter. I have enjoyed your testimony. You have been one of the best witnesses who ever testified.

Mr. McMahon. Thank you, Doctor.

Mr. Carter. I have no further questions.

Mr. Scheuer. The witness has been most patient with us, and it has been a most rewarding session, and I have benefited from your learning and we are very grateful for your testimony today. Thank you very much.

[The following letter was reecived for the record:]

American Hospital Association,
Washington, D.C., January 9, 1976.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

Dear Mr. Chairman: We are pleased to provide a further response to the following questions posed by your subcommittee during our appearance on December 9, 1975.

Question 1. What would the cost of the benefits of H.R. 1 be for a family of four?

Response. According to estimates developed by HEW[1] the average annual premium cost of an employee plan under H.R. 1 would be $330 (or $27.50 per month) for a single individual and $1,010 (or $84 per month) for an average family. The benefits package these premiums would purchase is of course broader than most existing plans provide. It would include preventive care, primary, specialty, restorative and health related custodial care, and would cover illnesses which result in catastrophic costs, including acute mental illness. Thus some costs now borne out-of-pocket even by persons with health insurance would under the bill be paid for by health insurance premiums. The mandated minimum employer contribution of 75% would mean the premium cost would be distributed between a minimum employer contribution of $247.50 (or $20.63 per month) and a maximum employee contribution of $82.50 (or $6.87 per month) for a single employee; and $757.50 (or $63 per month) minimum employer contribution and $252.50 ($21 per month) maximum employee contribution for an employee and family.

It is important to clarify that these figures represent an average group insurance premium and not HCC rates and they do not reflect subsidies to be provided because of low income of medically indigent status. HCC rates would be set prospectively by the state health commission.

Question 2. What are the phasing-in requirements for implementation of the Ullman bill?

Response. Assume, for example, that the bill is enacted on December 31, 1975. A 4½-year implementation program would follow:

Step 1 would begin on July 1, 1976. On the first day of Step 1, all present HEW health programs would be consolidated within the new Department of Health under the direction of a Secretary of Health. Also, at this time, Parts A and B of the Medicare program would be combined, and these benefits (without copayments and deductibles) would be extended to low-income persons, who are defined persons in the lowest income class referred to in the bill. The cost of the benefits for this income category would be financed totally from federal general tax revenues. Thus, the first step includes substantial federalization of Medicaid financing.

Also during the two-year period that would begin on July 1, 1976, the regulatory system would be developed through the establishment of new State Health Commissions in each state, meeting the standards established through the legislation and subsequent regulations. In addition, health care providers—physicians, hospitals, other health care institutions, and professionals— would be forming Health Care Corporations in communities across the country. Federal dollars would be used to support and encourage the formation of these new delivery systems.

Step 2 would cover a two-year period (July 1, 1978 to June 30, 1980). At the beginning of this period, the level of benefits included in the Medicare program plus catastrophic benefits would be extended to all persons on a financing basis identical to the fully implemented program. Thus, all employers would be required to provide, for their employees, at least this level of Medicare benfits and in addition the new catastrophic insurance provisions. These same benefits would also be made available to low-income and medically indigent persons. Those in the low income category would be fully paid for through federal general tax revenues. Those in the medically indigent category would be required to contribute to the cost of the benefits in relationship to their incomes.

Also during this period, HCCs would begin formal operations as soon as approval was attained from State Health Commissions. Individuals who registered with HCCs would be eligible to receive a federal subsidy for the cost of their health premiums.

Step 3 would begin at the end of the fourth fiscal year following enactment (July 1, 1980) and the full program would then be implemented. The bill's comprehensive health care benefits, broader than those available during the phase-in period outlined above, would be made available to all residents of the United States; the State Health Commissions would be in full operation, and all residents would be assured access to comprehensive health care services through at least one HCC.

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[1] *Estimated Health Expenditures Under Selected National Insurance Bills,* prepared by HEW, July, 1974.

A second major phasing in provision in the bill relates to the capitation method of payment. Capitation is defined as the method of paying for specific health services available to an individual or family based on a prospectively determined rate per individual or family, per unit of time.

In addition to key incentives for HCC's to operate on the basis of capitation included among the priorities for receipt of federal grants for planning, development capital, and operating subsidies, all HCCs after 5 years of operation would have to offer capitation to registrants as an *optional* method of purchasing comprehensive health care benefits. Note in these provisions that capitation for HCCs is an option to be available to registrants. In other words, risk sharing by providers is encouraged, but full risk assumption through total capitation is not mandated.

We are also glad to provide the following responses to questions submitted to us after the hearings.

Question 3. This Committee believes that the health planning legislation enacted last year was one of the most far-reaching health proposals ever enacted. An efficient planning system seems to us to be a necessary part of any national health insurance plan. Could you discuss the relationship of the State health commissions established by your bill to the health planning program enacted in P.L. 93–641. How would you see them fitting together?

Response. The Association is currently in the process of developing the system of dovetailing the provisions of P.L. 93–641 with the regulatory structure called for in H.R. 1. As I am sure you understand, this is a major project requiring much in depth work on the part of our staff. When this project has been completed, we will be pleased to share results with the Subcommittee.

Question 4. The Health Care Corporations are basic to your bill. These organizations seem to be somewhat similar in concept to HMOs. Could you explain how they differ? Would you think your approach would be workable if HMOs were used in place of the Health Care Corporations?

Response: There are several important differences between the HCC concept embodied in H.R. 1 and the Health Maintenance Organization (HMO) concept. HCCs would synthesize local health resources to provide comprehensive health care services to the population of a specific geographic area. HMOs would serve a defined (enrolled) population but would have no assigned geographic responsibilities.

The *geographic responsibility of HCCs* in the Ullman bill is, we believe, a key element in solving today's problem of access to health care. Without this responsibility, currently unserved groups such as urban low income populations and rural residents would continue to be left out of the system.

HCCs would cover *all communities* across the country and, as a broader system than HMOs, would assure that *all persons have the opportunity* to obtain comprehensive health services, irrespective of their place of residence or financial status. In addition, through areawide planning and the regulatory process carried out by the States under appropriate federal guidelines, strong emphasis would be placed on coordination among HCCs in order to eliminate wasteful duplication of facilities and services. HMOs, on the other hand; would—under current defintions—form on a "free market" basis and would not be integrated as a system, and there is no assurance that all communities would have them available to serve their population.

The HCC has great flexibility. The only requirement is that the organization offer comprehensive health services to a geographically defined population group. The ownership, organizational form or forms, methods of payment, etc., would be left up to community preference and procedure. The HMO is more restricted. HCCs can be paid on any appropriate prospective or prior-budgeted basis. HMOs by definition are paid on a capitation basis. This is another important difference in that capitation usually has the effect of requiring a provider organization to assume insurance underwriting functions. H.R. 1 encourages capitation through strong incentives, and mandates it as an option after five years, thereby allowing the needed flexibility where it is not appropriate for HCCs to become *an insurance organization.* Such flexibility is especially important in dealing with the delivery of services in high-risk areas.

For these reasons, we are convinced it would not be as effective to use HMOs as currently defined in place of HCCs.

Question 5. Would you elaborate on the make-up of the State Health Commissions—who will serve on the Commissions, how will they be funded, who will evaluate their performance, etc.?

Response: Under H.R. 1 States are required to establish an agency to implement and administer the NHI regulatory programs. The State Health Commission (SHC) would be composed of three or five members appointed by the Governor to staggered 6-year terms, with a balance between the two political parties. These commissioners would not be selected to represent any given interest group. They would be full-time salaried individuals not engaged in any other business. Input at this level from various provider, consumer and other interest groups would be provided through a state advisory council mechanism.

With regard to funding SHC's, the Cabinet-level Secretary of Health is authorized to make federal grants for the development of state plans by SHCs, on the following basis: 90 percent prior to the effective date of the benefit program, 85 percent for the next two years, and 75 percent thereafter. Funds not provided through this grant process would come from the state. With regard to performance evaluation, the Secretary is charged with carrying out continuous review of SHC performance and is empowered to step in and administer the program in any state which fails to comply with federal standards and guidelines.

Question 6. As you know, this Commission has responsibility for the Medicaid program. I think there is nearly universal agreement that Medicaid is inadequate—it fails to cover significant groups of the poor, for one thing. Additionally, benefits vary greatly from State to State, physician participation is often low, payment is slow, and so on. Nonetheless, with all its deficiencies, Medicaid has been an extremely important program for those poor who are covered. Could you discuss specifically the provisions of your bill for providing coverage to the poor? Are there premiums, copayments and deductibles at all income levels? Do you have any protection clause built in for people who have broader Medicaid coverage now than they would have under your program? Does Medicaid continue as a Federal-State matching program to provide the services your program doesn't include?

Response. Under H.R. 1 coverage for the poor (Income Class 1 of the bill) would be purchased totally by the federal government. Coverage for the working poor (Income Classes 2–4) would be purchased by the federal government with individuals sharing a portion of the premium. As income rises among classes 2, 3, and 4, individuals would be responsible for an increasing portion of the preimum, thereby reducing the federal subsidy.

With regard to copayments, the expenditure limits for the implementation of catastrophic coverage are designed so that individuals in Income Class 1 would have no dollar obligations for the covered benefits. For Income Classes 2–4, the expenditure limits are set very low and once reached, copayments and other limitations would be waived. Thus, inviduals and families in the various low income categories would be required to pay only modest amounts in relation to their ability to pay.

There are no specific savings clause included in H.R. 1 for individuals in states where the current Medicaid benefits would be greater than the comprehensive benefits package contained in the bill. Given the scope of the H.R. 1 benefit package, we believe there would be only a few states where such a problem would arise. However, with the federal government paying most of the cost of the comprehensive benefits package for low income or medically indigent categories, state funds formerly contributed to the Medicaid program would be available for the states to use for the State portion of the costs covering any additional benefits the State Medicaid program may have included and wish to include under Title XIX of the Social Security Act.

Title XIX would continue as a federal-state matching program but only for benefits supplementary to those provided under H.R. 1.

Question 7. The idea that a catastrophic health insurance program is what is most needed and perhaps most appropriate for the Congress to enact at this time seems to keep cropping up. You disagree. Would you like to elaborate on the reasons behind your view?

Response. We believe that any national health insurance program should provide coverage for illnesses involving expenses that are catastrophic to the patient and his family. However, we firmly believe that catastrophic coverage must be made a part of a comprehensive benefits package that would be made available to all persons, rather than be a separately financed and administered benefit because:

At the present time, 80 percent of the people in this country have insurance coverage for hospital services. A separate catastrophic coverage program could duplicate much of this coverage and lead to a downward revision of some private employer-employee health insurance policies to conform to the separate catastrophic program. Thus a solely tax-supported catastrophic coverage program would in effect shift to the government the entire cost of a benefit many employers and employees are meeting voluntarily.

The catastrophic coverage programs that have been proposed do not incorporate support for improvements in the health care delivery system that are needed if national health insurance is to be successful.

The separation of catastrophic coverage from the basic benefits coverage would create additional administrative expense in the health insurance system. There would be duplicative record keeping and claims processing requirements if a substantial portion of the population had basic coverage underwritten by private insurance carriers through employer-employee groups and catastrophic coverage under a government program. Under these circumstances, many benefit claims would have to be processed under both the basic coverage and under the catastrophic coverage. The administrative expense of doing so and of determining where liability rests would be substantial.

Separation of catastrophic coverage from the basic benefits package would create an undesirable rigidity in the system in that private carriers would not be free to develop broad benefits packages that could be adapted to the special need of various insured groups. In contrast, by requiring comprehensive benefits but allowing maximum flexibility in the design and adaptation of insurance coverage in the private market, substantial advantage can accrue in the form of broader coverage for the same price, or lower prices for the basic level of benefits.

Question 8. In your testimony, you indicate that philanthropy in the health care field should be preserved and encouraged. How does your bill do this? Why should it be done if we have a comprehensive national health insurance plan?

Response. Section 2(e) of H.R. 1 clearly spells out the Congressional intent to preserve and encourage philanthropy in the health care field:

"It is the intent of the Congress that appropriate philanthropic support for health care be continued and expanded under the program created by this act especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services. Nothing in this Act, therefore, is intended nor may be construed to eliminate or limit philanthropic support or incentives for such support for Health Care Corporations and Health care institutions."

In addition to the above language the bill also provides that institutions would not be required to use unrestricted gifts, grants, and incomes from endowments for on-going operational expenditures. Philanthropy for the non-profit endeavors. Philanthropy supports experiments and innovations that offer the opportunity to learn about possibilities for major improvements. We do not assume that national health insurance will finance every want. There will be limits on funds. Philanthropy offers the opportunity to exceed these limits.

Philanthropic funds which are to be used for capital purposes would under the bill be subject to the certification of need process. This latter provision is designed to assure that philanthropic funds will not be used for non-approved facilities or services, but, like all other resources development funds, will be subject to the health planning process and certificate of need laws.

Philanthropy has been and continues to be a very important factor in the financing of health care services. Consider the following:[1]

Between 1964 and 1973, annual charitable giving for health increased from $1.98 billion to $3.98 billion.

This increase of over 200 percent is greater than that received by religious or educational organizations.

Charitable giving paid for over 4 percent of the nation's total health expenditures in 1973.

Philanthropy provided almost 10 percent of the funds used for private, non-profit health and hospital construction in 1973.

Philanthropy provided $220,000,000 for medical research in 1973.

These facts demonstrate the importance of philanthropy to the financing of health care and medical research in the past and suggest that they can support needed innovation and help to fill local needs not otherwise financed in the future.

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[1] Source: 1. Giving USA, 1974 Annual Report, American Association of Fund Raising Counsel, Inc.
2. Hospitals, J.A.H.A., July 1, 1974.

Question 9. The benefit package eventually required under your bill is extremely comprehensive. Have you estimated the cost of that package? In today's dollars, or whatever you have, what would be the premium for that package?

Response. As stated in reply to Question #1, the monthly premium under the employee plan is estimated by HEW to be $27.50 for a single individual and $84 for a family, with the employers paying at least 75% of the premium.

Question 10. You have quite a complex set of requirements for copayments in your bill—20 percent copayment on dental service, $2 copayment on some home health services. $2.50 copayment on nursing home care, $5 copayment on hospital care. Would you comment on why you selected this rather complex structure?

Response. First of all, we do not believe that the copayment structure in H.R. 1 bill is unduly complex. It was designed to incorporate a reasonable level of cost-sharing for various services without presenting barriers to the provision of care. Additionally, the bill would streamline the administration of the benefit package and the collection and payment function for carriers through the health card.

Question 11. While you have copayments in your bill, you don't seem to have deductibles. Could you elaborate a little on why you designed your bill in this manner?

Response. The imposition of a substantial cost sharing requirement through deductibles and high copayments as provided in the benefits packages of some national health insurance bills is of concern for two reasons. First, the administrative cost of a deductibles program is too high when compared with the dollars saved through the use of deductibles, especially if the health card concept is not included in the program. Normally, much of the cost of administering a deductible is experienced in relation to persons who never become eligible for payment. Second, a high level of deductibles could become a barrier to individuals seeking or receiving needed health care services.

Question 12. You provide a 10 percent premium subsidy for anyone enrolling in a Health Care Corporation. This seems to be one of the few bills that encourages one sort of coverage mechanism through subsidy. Tell us why you think this is justified?

Response. H.R. 1 includes several incentives for the development of HCCs, and this is one of them. While it is critical to develop a benefit package that is comprehensive for the total population, we believe the federal government would be remiss in its obligation if, at the same time, it did not provide a mechanism for restructuring the delivery system and its resources so that the benefits financed could be delivered as effectively as possible. It is our assessment that the existing system could not fully respond immediately to the increased demands that will inevitably follow the enactment of national health insurance legislation, but we believe firmly that the private sector can and will meet the nation's health care needs, given appropriate support for development of the needed resources and of the changes in delivering required to make the use of available resources as effective as we can.

Question 13. Your Health Care Corporations provide for quite a big change in the organization of our medical care system. Do you realistically think they could be developed and in place in five years? Has the experience with the implementation of the PSRO and Planning programs changed your view at all?

Response. While the experience to date with regard to implementation of the PSRO and planning programs has been disappointing, we still believe that development and implementation of the HCC structure in five years is a reasonable goal. There are several reasons for this belief. First, the PSRO and planning structures are being developed and put in place by governmental agencies. Under H.R. 1, the initiative for developing and establishing HCCs would come from providers. Second, the various mandates and incentives in the bill would help promote the activity. Placing the responsibility for restructuring of the health delivery system where it belongs—on the providers—would, we believe, increase the likelihood of success. The selection of a 5-year period is of course somewhat arbitrary and is based on the assumption that adequate financial support to the development of HCCs will be made available. Such action will require a proper and timely response by federal and state agencies in developing the necessary regulations.

Question 14. You changed your bill this year to adopt use of the Health Card Concept that was in the Administration bill last year. Yet some people have criticized the Health Card Concept saying it is beyond our capacity to administer, that it would put the insurance companies and eventually the States in the bill collection business, etc. Would you comment on why you thought the Health Card Concept should be added to your bill?

Response. First of all, the health card concept has always been in the bill, although in previous versions it was limited to registrants of HCCs and did not have the specific label of "health card." In the current version of the bill, the provision was expanded to apply to everyone and was more clearly identified as the "health card" concept.

We strongly support the "health card" approach as an important mechanism for reducing barriers to care, for eliminating discrimination because of the source of payment, and for increasing the administrative efficiency in the overall payment system. It would simplify rather than complicate the administration of the program. The concept provides for issuance of a health card to each covered beneficiary. This card would be evidence of eligibility for care and would provide for copayments first being paid by the insurance carrier and settled subsequently between the carrier and the patient. This system would eliminate a patient's need for cash at the time of service and would eliminate any "means test" at that time. The development of a mechanism such as this is sorely needed, and is a function that insurance carriers can effectively perform.

The bill in several different provisions has sought to centralize in the hands of carriers collection and reimbursement functions so that duplications in administration could be eilminated. The bill's provisions transfer the burden of collection from providers, so that they can devote their energies to providing care, to the carriers because it is a responsibility that is consonant with those functions they are already set up to perform. We believe that administrative efficiency will thus be enhanced, not undermined, by the health card approach.

Question 15. Would you elaborate on the assistance you provide to small employers to help them meet the costs of the required insurance coverage? Why did you change to a tax credit approach?

Response. The assistance provided to small employers (10 or less employees) in meeting the cost of providing the mandated level of coverage is in the form of a tax credit for premium dollars that exceed 4 percent of the average wages for his employees. We chose the tax credit approach because we believed it to be the simplest and, therefore, the most easily administered way to provide this subsidy. The primary purpose of the subsidy, of course, is to ease the burden of a new program on those firms that are least likely to be able to finance the additional expenditures required by the bill and where the burden is particularly heavy.

Question 16. Your organization has great expertise in hospital reimbursement questions. Could you elaborate on the reimbursement system for hospitals proposed in your plan? Almost all the bills seem to use some sort of prospective reimbursement system. Can we expect this kind of payment will help hold down the increases in hospital cost and expenditures?

Response. Throughout the nation, institutional health care providers are being paid for their services under a variety of systems, ranging from retrospective cost-based reimbursement to prospective payment systems. Some of the prospective approaches are quite new and are still being evaluated. The Department of HEW reported that as of March 1974 there were 26 prospective payment systems in existence in 22 states, involving 25 percent of the nation's hospitals. HEW's report identifies three general categories of prospective systems, each of which may use any of four general bases for determining reasonableness of rates and any of four different units of payments.

The American Hospital Association favors use of the prospective payment mechanism under national health insurance. On the other hand, because of the variety of approaches available within the "prospective" label, and because of the relative newness of these approaches, it appears premature to mandate in any national health insurance law the use of a single specific method of prospective payment for institutional providers of services. Therefore, it is our view that any national health insurance program should provide for the establishment after consultation with hospitals and others, of one or more payment methods within each state. Payment methods that are to be developed on a state-by-state basis, in accordance with regulations of the Secretary, could be based on budget review, target rates, negotiation with third parties, formula or other appropriate methods. States should be permitted to develop more than one system and where this occurs, providers should have the option of selecting from the alternatives. Once a system or systems were established in a state, they would apply uniformly to all payers, including the federal government.

Inherent in any prospective payment system is the possibility that estimates of activity may not be realized and that estimates of cost trends may be exceeded.

It is, therefore, important that the service continuity of hospitals not be jeopardized by unpredictable changes in utilization, revenues, or costs. A reasonable operating margin will provide the needed flexibility to meet such potential developments and help avoid recourse to alternate high-cost capital such as short-term borrowing, and it offers a source for developing equity funds for improvement of services, subject, of course, to planning approvals. H.R. 1 provides for this flexibility of payment mechanisms.

Prospective payment systems, in and of themselves, will not eliminate increases in the cost of health care. However, they will lead to a more accurate identification of costs and the development of financial goals which can then be utilized in those processes that will help to contain costs in line with the goals of the program. Better planning and better coordination of the delivery system through the efforts of HCCs and SHCs will be facilitated if done in conjunction with prospective payment.

Question 17. One of the great difficulties we seem to have with our current health care financing arrangements is that there are some people who because of their age or work status or existing health conditions or lack of connection to the Social Security system or whatever fall through the cracks and have no coverage at all. Are there any groups of people who are left uncovered under your plan?

Response. The bill attempts to cover all gaps. The only group of people excluded from coverage under the bill are employees of the federal government and its agencies. With regard to those groups usually thought of as "left out", the bill mandates coverage for the employed, the self-employed, and "uninsurables". State-wide pools would be developed for these categories, and all carriers offering the comprehensive benefits package would be required to participate in the state pool as a condition of certification. In addition, there are provisions in the bill to provide tax credits with respect to premiums paid generally speaking, in excess of 4% of adjusted gross income when they are not eligible for insurance under the various other provisions of the bill.

Question 18. Could you discuss the mechanisms you have built into your plan to assure quality of medical care and appropriate utilization? Do you see the PSRO mechanism? Do you think the experience we have with PSRO so far justifies relying on it for quality review under NHI?

Response. With regard to the bill's provisions for quality assurance, the HCC is responsible for:

Compliance with standards of quality and comprehensiveness established by the Secretary.

Maintaining controls on utilization of services.

Continuing appraisal of the effectiveness of services.

Identifying problems that require planning for additional services.

All HCC's would have the capacity to perform these functions.

To these ends, the HCC is required to have a system of comprehensive peer review by physicians which covers all services provided by the HCC and its affiliates. The bill also requires that the HCC maintain a program of continuing education for its physicians, dentists and nurses.

The Association has long espoused the belief that quality assurance and utilization review mechanisms should be focused at the institutional level with outside monitoring to assure that institutional programs comply with standards and guidelines. Institutional providers have been involved in quality assurance and utilization review programs for many years, whereas PSROs are just barely getting off the ground. Consequently, the majority of experience to date relates to programs at the institutional level. We see the PSRO mechanism as being the outside monitor. The Association's staff is now undertaking a detailed evaluation and analysis effort on the question of how the two processes would meld. We would be pleased to share the results of this effort when it is completed.

Question 19. The Administration seems to feel that this is not the time to pass a national health insurance bill. Would you like to comment on this?

Response. While the cost of a national health insurance program may be large to absorb at this particular time, we are talking in H.R. 1 about a phased-in program with little added cost for over two years. However, the success of the program depends in large part on enacting the entire concept and developing each of its stages, prior to the implementation of even the first step. If Congress goes about enacting national health insurance on a piece-meal basis without an overall plan, the existing fragmentation in health care delivery and financing may be perpetuated. We believe that now is the time for Congress to move ahead in developing the entire legislative concept for future step-by-step implementation.

Question 20. Could you discuss the kinds of preventive services you cover in your bill? Are copayments or deductibles applied to these preventive services? I'm interested in your views on whether simply financing this kind of care is sufficient, or whether there should be development of particular delivery mechanisms, like maternal and child health centers.

Response: The preventive services provided in the bills benefit package are periodic screening, immunizations, well-baby care, and certain aspects of dental care and eye care. Health education activities are also encouraged. Copayments are not required except for certain aspects of dental and eye care. Limitations on preventive services are to be determined by the Secretary on the basis of available resources.

We do not think that simply financing these services is sufficient. Consequently, the bill encourages, through a grant program, the establishment and/or expansion of outpatient care centers as part of the development of the HCC system. We believe such activities should be tied in directly to an organized continuum of care, rather than supported as free-standing efforts.

Question 21. Could you discuss how doctors get paid under your plan?

Response. Under H.R. 1, payment for services rendered to hospital patients by hospital-based physicians (e.g., radiologists and pathologists) would be included in the institution's charge for care. Individual physicians or physician groups would negotiate payment arrangements with the HCC and could be paid in any appropriate manner. For services rendered on a fee-for-service basis outside the institutional setting, physician fees would be established through a system developed by the SHC.

Question 22. Could you discuss the drug coverage provided by your plan? Do you cover a wide range of drugs or maintenance drugs only? Do you have a separate system of deductibles for drugs? How is reimbursement handled—do you use a concept similar to maximum allowable cost?

Response. Drugs normally prescribed during covered inpatient stays are covered without any specific limitations. There is a $1 per prescription copayment required for outpatient drugs. The Secretary is also required by the bill to develop a formulary for drug coverage, geared primarily to those drugs which produce high costs or involve important intensive therapy. The bill includes provisions similar to those of the maximum allowable cost concept—covered drugs are to be listed by established name and rates of payment are to be established by the SHC's.

Question 23. Do you think that we eventually need to develop a companion program to national health insurance dealing with long-term care?

Response. We do not believe that long-term health care should be handled separately from national health insurance, but rather should be incorporated and integrated into the overall program. First of all, long-term health care is frequently part of a total patient care plan that includes other modes of care and its separation from national health insurance would lead to costly inefficiencies in administration. Secondly, national health insurance provides the opportunity to deal with the existing fragmentation of the delivery and financing of health care, and we believe that a separate long-term care program would diminish severely the ability to eliminate fragmentation through legislation along the lines of H.R. 1. However, long-term health care and housing and maintenance needs are closely intertwined and as a consequence comprehensive provisions to deal with this problem have not been included in the bill.

Question 24. You have broadened coverage of benefits for acute mental illness in your bill this year. You mention that recent evidence indicates that there are not rational grounds for providing severely limited benefits for mental illness. What is the evidence? Can you elaborate on this a little more?

Response: The evidence we have referred to with regard to coverage of benefits for acute mental illness is contained in an HEW publication[1] which resulted from a 2½-year study conducted by the American Hospital Association under a cost-sharing contract with the National Institute of Mental Health. For a more detailed discussion of the results of this study and the Association's policy that stemmed from it, I am attaching a copy of our recently published statement on Financing of Mental Health Services Under a National Health Insurance Program.

Sincerely

LEO J. GEHRIG, M.D.,
Senior Vice President.

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[1] *Financing Mental Health Care in the United States—A Study and Assessment of Issues and Arrangements.* Published by National Institute of Mental Health, 1973. DHEW Publication No. (H6M) 73–9117. [Not printed.]

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

Our last witness today will be Mr. Roger C. Sonnemann, vice president, administration and employee relations, AMAX, Inc., on behalf of the Chamber of Commerce of the United States of America.

We appreciate your patience, and we appreciate your being here. You may proceed as you desire.

STATEMENT OF ROGER C. SONNEMANN, MEMBER, BOARD OF DIRECTORS, AND CHAIRMAN, SPECIAL COMMITTEE ON THE NATION'S HEALTH CARE NEEDS, CHAMBER OF COMMERCE OF THE UNITED STATES, ACCOMPANIED BY ROSE P. WOODEN, COMMITTEE EXECUTIVE, SPECIAL COMMITTEE ON THE NATION'S HEALTH CARE NEEDS

Mr. SONNEMANN. Thank you. Accompanying me is Rose Wooden, who is the committee executive of the chamber's Special Committee on the Nation's Health Care Needs.

Mr. ROGERS. We welcome you.

Mr. SONNEMANN. We welcome this opportunity, Mr. Chairman, to update our views of the chamber on national health insurance, and this statement supplements the letter giving our views on this matter to you on June 12, 1975.

These issues are of vital concern to our membership, and our membership embraces some 48,000 business enterprises and represents in total something like 5 million individuals and firms.

THE NATIONAL HEALTH STANDARDS BILL (S. 2644)

Our Special Committee on the Nation's Health Care Needs, composed of business and industrial leaders and members of health professions, helped develop the national health standards bill, S. 2644,[1] sponsored by Senator Paul J. Fannin.

The terms "reasonable" and "realistic" most accurately describe this bill which we support. However, we urge caution in implementing any national health insurance proposal until solutions are found for the causes of health care inflation, improvements are made in planning health care delivery systems, and effective incentives are found to offset rapidly rising health care costs.

Let me make it clear the business community and the chamber support the goal of a national health care system that would assure access to quality care for all Americans at reasonable total costs for services provided. Such a system should maximize the advantages of individual freedom of choice and flexibility.

There are, we think, certain basic principles which should be embodied in any national health insurance program, and these should include the provision for universal financial access to health care through both private and public means; provide public financial assistance for the poor, near poor, and the unemployed; build on our existing hospital and medical care delivery systems with underwriting and administration supplied by private enterprises; protect individuals and families against the devastating impact of very costly and prolonged illness; provide a benefit package which is comprehensive in scope; provide for cost sharing on the part of beneficiaries; and provide for effective measures to help contain spiraling costs.

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[1] See p. 1126 for full text of S. 2644.

When S. 2644 is adopted, working Americans and the unemployed will have health coverage in harmony with the above principles, as will those who are on welfare.

The question is not so much "should we provide health insurance for all Americans—we think that bridge has been crossed in the affirmative—but rather "how should we design a new national health insurance program that is affordable by the Federal Government, the individual consumer and employers?"

We have learned that the traditional market controls inherent in the price system do not operate in the present health care system. This can be directly attributed to the rise in health insurance coverage, private and public.

I think it is fair to say parenthetically here in the introduction on November 11 into the Congressional Record of Senate 2644, there were certain statistics quoted which give us a background as to the scope of the problem and these include—and I refer the committee to—pages 19610 of the Congressional Record of the Senate of November 11, 1975, where the gaps in private health insurance are listed based upon data from the Social Security bulletin of February of this year.

The title of this record shows that some 22 percent had no hospital
insurance, but that means in the positive that 78 percent of the popula-
percent had some kind of surgical insurance and about 77 percent
tion did have some kind of hospital insurance, and similarly, some 78
had some kind of inhouse hospital medical expenses.

What we are really talking about and the thrust of the chamber's position is that we have a private system which has done extremely well by the vast majority of our citizens, and we recognize at the same time that there are these gaps which we think should be filled in order that all Americans should have an equal opportunity to quality health care.

The problem, however, is that there has been a soaring cost which we attribute to the fact that the traditional market controls just don't operate in this area.

There has been a rise in health insurance coverage, private and public, as the statistics quoted make plain. The third party effect of health insurance causes market distortions. The cost of health care is directly related to the scope and level of health care protection desired.

Once the insurance premium is paid to the third party insurer, the natural incentives are there to demand and provide the best care if there is the slightest possibility that it might be beneficial.

The increases in private and public insurance coverage has acted, in part, not to replace personal expenditures for health but to increase costs by making physicians and consumers alike less sensitive to them.

Current social attitudes that health care is a "right" expose the health care system to an infinite demand. The decision to seek certain types of medical care is frequently made for consumers by doctors and hospitals. Lack of coinsurance and deductibles, as Mr. Scheuer seemed to point out earlier, encourage overutilization and overloading of the health care system, particularly by the "worried-well."

The present reimbursement mechanisms and uncoordinated health planning have led to hospital bed overcapacity and attendant heavy hospital overhead. To make matters worse, every community is encouraged to develop a sophisticated medical delivery system, often with the aid of Government funds.

While I was horrified to hear the references to the letter that was put in the record concerning one hospital administrator to the doctors that Mr. Scheuer referred to, I think that this probably represents the attitude not only of hospital administrators, but of many communities, particularly in urban areas where we have read in the public press that the citizenry has banded together and taken to the streets in protest over proposed closing of hospitals where there has been less than 30 percent utilization of bed capacity, and this is a very serious problem because everyone would like to feel that excellent health care is immediately available around the corner from where he lives, whether in the city or in the country.

Our health system has been termed a "nonsystem" because it is not organized on a rational basis which would provide services in the most cost-effective manner possible. Many experts have said that the costs will not be brought under control until a basic restructuring of the system takes place.

Prepaid health care plans are only one type of restructuring that may prove beneficial. You will note that in Senate 2644 we specifically refer to the health maintenance organization and make provisions for them as an alternate.

We believe, in other words, in the health maintenance organization as one concept for helping to contain the costs of Medicare care while providing better medical care.

As the demand for quality medical care expands, supply expands less rapidly because of many factors. Medical services are maldistributed rather than unavailable. For example, there is a geographic maldistribution of physicians and an imbalance in the mix of physicians specialists.

National health insurance will not solve these problems. In fact, it will tend to aggravate problems of health care delivery in rural and inner city areas where medical facilities and physician services do not exist, or are very scarce. Pouring more money into a national health insurance system will not solve the problems of those most in need in such areas.

Americans already spend more on health care than any other people. We are spending $118 billion this year—8.3 percent of the GNP, up 0.6 percent from 1974—a rate of growth in excess of the 0.5 percent growth over the previous 5-year period. Yet, we are slipping behind other nations in many important measures of health. The sobering fact is that the health status of the American people has not substantially improved. Increased Government subsidizing of health care expenses, without substantial improvement in the efficiency of the health care system, will only accelerate the alarming rise in medical costs. Conversely, if efficiency is improved, there may be less need for Government subsidies.

CATASTROPHIC HEALTH INSURANCE

The chamber supports the concept of catastrophic health insurance and believes that Americans should be protected from bankruptcy brought on by medical bills. But, any program which provides only catastrophic protection is incomplete and does not represent an adequate response to people's needs, which go beyond the statistical probability of medical catastrophe.

For example, such insurance would not encourage more cost effective preventive care, nor would it help children and young women of childbearing age who need regular checkups. Making available additional health dollars to pay for medical catastrophe would encourage providers to use the most advanced technology available regardless of whether or not the benefits can be justified. Medical treatment will follow the health dollars as it has in the medicare and medicaid programs.

We believe that a simple catastrophic health insurance bill per se is consonant with building a chimney from the top down. Private catastrophic health insurance is available today at reasonable rates.

Based on a recent survey, the Health Insurance Institute estimated that 150 million persons under 65 now have private catastrophic health coverage for $10,000 or more. This includes coverage under major medical, Blue Cross, HMO and other high basic coverage plans, such as the UAW's. On the other hand, at the end of 1974, over 165 million persons under 65 had private coverage through hospital expense plans. This illustrates that more Americans under age 65 have chosen to purchase for the more probable hospital episode than for the catastrophic episode. It also illustrates the existing breadth and depth of coverage in these two areas.

We recognize the appeal of the new catastrophic proposal that allows an employer to choose between a private plan and a public plan administered by the Social Security Administration. But, there are no caps, ceilings or incentives written into the proposal to contain costs or improve the delivery of care.

Acceptance of payroll tax financing of health care on a universal basis—meshed with a Government operated program of catastrophic benefits for part of the population—would border on a total Government health care program.

I want to state unequivocally the business community is united against this kind of arrangement. Experts question whether or not the 1 percent proposed payroll tax will do the job, given the current rate of health cost increases.

Whether it does the job or not, it is our view in business that additional payroll taxes are unacceptable to us as a means of financing whatever health care may be legislated.

This proposal comes at a time of growing concern over future social security deficits. This year, we will pay out more in social security benefits than is collected in payroll taxes from employers, employees, and the self-employed. The 1974 Annual Report of the Trustees estimated a long-term 3-percent taxable payroll deficit in social security. Experts reporting to the Senate Finance Committee have estimated the deficit at 6 percent of taxable payroll. The House Ways and Means Committee has learned that the trust funds may be depleted by 1980.

No one sees how we can add 3 to 6 percent to the current combined social security tax rate of 11.7 percent. Yet, Ways and Means has been considering proposals to increase unemployment compensation payroll taxes on employers by $6 billion or more a year.

If we follow the path that some have suggested, there will be a further payroll tax for consideration, and we submit that this is an intolerable burden.

TIMETABLE FOR NATIONAL HEALTH INSURANCE

The Nation faces three big problems that must be resolved before enactment of national health insurance legislation. These problems are the slow recovery from recession and high unemployment, the continuation of inflation, and the energy crisis.

These problems have delayed national health insurance. The delay is fortunate, giving Congress and all interested parties time to reassess the value of national health insurance, its costs, and the economic problems it will cause.

I am under no illusion that the suggestion of further studies in these areas is popular. It seems to me the facts cry aloud from what we heard earlier this afternoon that there seems to be no reasonable way of containing costs if a private doctor decides a private patient needs to go into the hospital and this is his best judgment, this is what will happen, and particularly if there is a broad coverage, as exists under private insurance plans, there is no question that the patient will expect to do what the doctor recommends and hospitals will have to be there to provide it.

The Federal Government has already plunged deeply into health care and without satisfactory results. The Department of Health, Education, and Welfare estimates that medicare and medicaid expenditures will jump from $25 billion in fiscal year 1976 to $30.4 billion in fiscal year 1977, an increase of $5.4 billion.

The inflationary increase in medicare and medicaid expenditures will exceed the total budget for all other HEW health programs, amounting to some $4.5 billion in fiscal 1976.

The enactment of medicare and medicaid offers an example of how not to proceed with national health insurance. The social conscience and political pressure which prompted the Congress to adopt these measures were not accompanied by a comparable effort to encourage large-scale introduction of more effective systems for providing medical services.

As a result, in the past decade, close to one-half of the increase in spending has been for higher prices for medical care rather than for increased services.

The inexorable rise in the price of components of medical care has led some to believe that national health insurance is the only way to control these costs. But, our experience under medicare and medicaid is not reassuring in this regard. We cannot afford to raise unreasonable expectations as to how much some future national health insurance system will do for our citizens or how little it will cost them.

On the whole the health insurance and medical care industries are serving the American people quite well. I think they, and we, can point with pride to the progress that has been made over the years in getting more and more people covered under some form of private health insurance. Under the present economic circumstances, we submit that it is prudent to put new expensive insurance plans in perspective while we are trying to restore a healthy national economy.

GOALS FOR BETTER HEALTH CARE

We recognize certain goals for an improved health care system. These goals are: (1) Better geographic distribution and specialty mix of health care manpower, and as I pointed out earlier, this is one of the major problems we have; (2) better health care planning; and (3) improved health care delivery.

These goals are consistent with the American traditions of freedom of choice, self-reliance, and efficiency. Corporate interest in cost containment and improved health services is logical, for the business community is the largest consumer of health care. Business is becoming a smarter purchaser of health care because it pays heavily for health delivery inefficiencies.

HEALTH CARE MANPOWER

The National Chamber, in general, supported the House-passed health manpower bill, recognizing that geographic maldistribution of physicians has denied access to care for many Americans. We know that the present mix of physician specialists and the overabundance of superspecialists in certain areas has had an inflationary impact on health care costs.

This inflationary impact reflects the fact that within limits, the physicians create their own demand. We believe the House of Representatives acted responsibility in passing the health manpower bill, which was partially aimed at effectively delivering health care to the poor, either in urban or rural areas, and improving the specialty mix of physicians.

The urban poor need improved access to health care facilities which are better related to health problems in urban ghetto neighborhoods. All rural citizens, not just the poor, deserve more imaginative methods for delivering health care. Mobile clinics, effective emergency service, and computer medical technology are possibilities.

I think we ought to add in remote and sparsely settled areas the use of helicopters because this is certainly being used in the mining industry in which I have the privilege of serving.

The problem areas seem to be prmarily a definition of purpose, leadership selection, and overall organization, and only secondarily in technology.

HEALTH PLANNING

Better responsibility, accountability, and coordination of health care are needed. Businessmen are actively involved in implementing the National Health Planning and Resources Development Act—Public Law 93-614. The National Chamber staff and the Special Committee on the Nation's Health Care Needs are developing useful information to help guide businessmen in making the difficult decisions involving their community's health needs.

Regulation of the health industry should avoid the mistakes made in regulation of railroads, airlines, and other industries. Truly effective health planning would stimulate improved services and reward innovative ways to contain costs, and not lock in traditional methods that are not cost efficient. Special emergency care units can have eye banks and all the other spohisticated services and facilities that are so badly needed and used in toto today, but not every community can have them, and it is this kind of coordination that I think will help make this cost efficient.

We just can't afford prestige facilities in all of our hospitals. We have become acutely aware in the business of the inflationary impact of expensive medical equipment, such as cobalt therapy machines and cardiac surgical units.

Needless duplication of services and wasteful competition for prestige purposes must be avoided. Business has become acutely aware of the inflationary impact of expensive medical equipment, such as cobalt therapy machines and cardiac surgical units.

Purchase of expensive—over $100,000—medical equipment by hospitals is subject to control by area planning agencies, but purchase of such equipment by individual doctors is not controlled. This can lead to unnecessary costs.

More accountability and responsibility is needed on the part of community hospitals. They should publish detailed financial statements, including contractual terms of payment for the services of specialty groups. The reimbursement formulas for hospital-based physicians—for example, radiologists, pathologists, et cetera—should assure that such services are not overutilized and that unnecessary equipment is not purchased by hospitals.

Business is cooperating with community hospitals. I think you would be amazed at the extent of this cooperation in developing such innovations as prospective reimbursement rate systems, taking into account hardship relief for hospital bad debts and charity cases.

Training programs are needed for those who serve as trustees or who are on the governing boards of hospitals or similar institutions, to insure enlightened service. Business can and is participating in decisions that affect the cost of hospital care. Application of sound business methods and management techniques often have a decidedly favorable effect on costs.

The National Chamber also recognizes the serious consequences of medical malpractice suits, including rising insurance rates, the practice of defensive medicine, the increasing frequency of suits, the large size of awards under the deep pockets theory, and the adverse effects on already limited manpower. We are encouraging local and State chambers and the business community to work with the various interest groups involved to find statewide solutions to this problem.

Let me say here and now this is a very complex problem in itself because of the varying tort laws in the several States, and I have in my bag, and just received from a special subcommittee on the laws in the various States, a series of recommendations which will be looked at carefully from a legal point of view and passed on to the local chambers of commerce for use at the local level in trying to find a solution to this medical malpractice problem, which is a mounting catastrophe in the country.

Mr. SCHEUER. May I interrupt the witness for one moment?

We have just had the second bells, and we will have to leave in a minute or two. Let me say that in all of the hearings that I have heard, I have never heard a more incisive and thoughtful definition of the problems that we face in putting together a national health program.

I think your analysis is absolutely brilliant, and I thank you for giving it to us. I am not sure that I don't have some reservations about your proposal to remedy the problems, but I think you have rendered a very great service to this committee in your incisive analysis of the problem facing us, of the spectrum of the design and organization and delivery and payment of health services, and I want to thank you most appreciatively for the great help you have given us, at least in analyzing the problem, which is the beginning of all progress.

Mr. SONNEMANN. Thank you, sir.

Mr. ROGERS. May I interrupt now. We do have a call on for a vote, and the committee will stand in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order. We apologize to you for the vote, and you may proceed.

Mr. SONNEMANN. Thank you, sir. I shall be brief in my concluding comments.

We want to reiterate our support for the HMO approach as one viable alternative which has some cost containment provisions by its very nature.

We also would like to say that the problem is not whether we are going to have some kind of national health insurance for the 20 percent of the country that is not yet covered, but the problem really is to find a way to get them under coverage and at the same time not do acts which we will regret in retrospect in terms of building and setting in concrete certain principles and certain operations that avoid the recognition of the problem of cost containment.

We believe that an increased payroll tax is unwarranted and unworkable and has the entire business community stirred up in opposition thereto.

We believe that Federal subsidization of health care costs without substantial improvement in the effectiveness of the system will only accelerate the current and alarming rise in medical costs.

We believe that before such a national health insurance program should be adopted and as Congress addresses itself to the other urgent problems facing our economy, we support this committee in its efforts to reexamine all aspects of the question.

Because it is so potentially inflationary, because the availability of insurance is not an acute problem for the great majority, enactment of national health insurance should be postponed until better handles are found to the problems.

Finally, sir, we commend to your attention exhibit A, attached to this statement [see p. 211], and in particular to the statement by the sponsor of S. 2644 in introducing it in the Senate on November 11.

One final statement. As you read the provisions of S. 2644, you will recall that there have recently been hearings on the extension of health insurance to the unemployed. S. 2644, had it been in effect, would have made those hearings unnecessary because it contains such a provision.

As you are also aware, there has been a considerable debate and discussion and hearings on catastrophic insurance. S. 2644 provides for catastrophic insurance as an adjunct to basic coverage. There are in S. 2644 certain cost containment provisions by way of deductions and copayments, coinsurance. We think these are necessary in order to keep before the users at all times the real costs that are involved in these things.

When a person finds 100 percent of the cost of a particular benefit or service paid for entirely by someone else, he looses the perspective of its value and the costs related thereto.

In conclusion, the business community is intensely interested in doing the right thing with respect to national health insurance, and we are generally supportive of it. We believe it has to be put in a proper perspective that considerable further study needs to be had in the area of what really is causing the spiraling costs and what can be done about it.

We do not feel that the doctors are all evil or that the administrators of hospitals are all ignorant of the problems. We believe that our system is basically very effective for the vast majority of Americans, and it needs improvement, but improvement cannot be had simply by throwing substantial sums of money against it.

Thank you very much, Mr. Chairman.

[Exhibit A, referred to follows:]

EXHIBIT A

RECOMMENDATIONS ON NATIONAL HEALTH INSURANCE LEGISLATION

(Chamber of Commerce of the United States, November 22, 1974)

The design and implementation of any National Health Insurance legislation enacted by Congress should be based upon the following principles:

1. There should be universal financial access to the coverage for essentially the entire population, through both private and public means. Where the employer-employee relationship exists coverage should be mandated. Employees should be required to accept coverage if employers are obligated to offer it. For small employers, or self-employed persons, coverage should be available from a special insurance pool. Where the poor and near poor are involved, coverage from a separate, government-assisted pool should be available.

2. The plan should build on our existing hospital and medical care delivery systems with underwriting and administration supplied by private enterprise, including commercial insurance and Blue Cross/Blue Shield plans.

3. The benefit "package" should be comprehensive in scope providing protection against a wide range of hospital and medical care expenses, i.e., hospital, surgical, diagnostic, lab and x-ray, radiation therapy and in-hospital medical expenses plus out-patient surgery, maternity, psychiatric, ambulance, post-hospital extended care and physiotherapy, etc.

As part of the overall benefit "package," every covered individual should be protected against the devastating impact of very costly and prolonged illness—the medical catastrophe. Such protection should be through a major medical provision with no lifetime limit.

4. Benefits should be phased-in over a 5 year period to ease inflationary pressures and to ensure availability of services.

5. The plan should provide for a benefit equivalence test to recognize the varying needs and differences, including geographical, of individuals and groups thus allowing flexibility in the makeup of hospital and medical care plans. Also, current highly sophisticated and generous benefit plans should not be forced to add additional benefits and additional costs where the benefit equivalence test is met or exceeded.

6. The plan should provide for cost sharing on the part of beneficiaries by appropriate deductibles and co-insurance provisions.

7. Employers should be encouraged to make the mandated plan available through the process of administrative and judicial review with civil penalties assessed in instances of non-complicance.

8. Any NHI legislation should attempt to curb spiraling health care costs through fair and effective means. First, all hospital and medical care services should be subject to peer and utilization review, claims review and audit. Peer

and utilization review should be carried out by physicians to insure that only medically necessary services are provided to both in-patients and out-patients. Employers should be permitted to contract directly with physicians to establish peer review, certified hospital admission programs and systems of accountability to determine whether a company's health care dollar is being properly spent. Second, hospitals and other institutional providers should be reimbursed on the basis of prospective budgets, with payments based on agreed rates for a fixed period of time. Third, duplication of facilities and provision of unnecessary services should be avoided by prior approval by local health planning bodies and nonpayment for disapproval capital expenditures.

9. Any NHI legislation should provide for the option of enrolling in an approved health maintenance organization, such as prepaid group practice or medical care foundations, in lieu of coverage under a mandated plan. This option should include adequate safeguards to ensure proper coverage, high quality care and a limit on the employer's financial obligation equal to the costs of his existing health insurance program.

10. Any National Health Insurance program should be financed from both public and private sources. Employers, employees and the self-employed should pay the entire cost of the mandated program through health insurance premiums. Where the employer-employee relationship exists, the plan should mandate no more than a 50-50 cost-sharing of premiums with provision that an employer may voluntarily assume the payment of part or all of the employee's share of premiums. A program for the poor and near poor and unemployed should be financed from the general funds of the Treasury. Eligibility and individual premium payments should be based on income level or other appropriate measures.

No part of the cost of NHI legislation should be secured by any payroll tax. This will lead to government control of health care delivery and undermine the present effective private enterprise system with respect to furnishing and financing health care.

11. The Medicare program should remain intact and unchanged by any National Health Insurance legislation. Medicaid should be repealed since it would be supplanted by the health insurance program for the poor and near poor.

Mr. ROGERS. Thank you very much for your testimony and a most helpful statement.

We may, as we get into specifics, want to ask you or your representatives to come back to discuss the specifics of the particular legislation.

Mr. SONNEMANN. We will happy to do that.

Mr. ROGERS. I did wonder why you exclude coverage for physical exams and immunizations in the bill. Is there any particular reason to exclude these when they are preventive medicine?

Mr. SONNEMANN. No, there is no particular reason. It was a matter, I think, sir, of cost. This may be a very valuable adjunct which needs to be added.

Mr. ROGERS. Yes. I wondered if there was any strong feeling on that?

Mr. SONNEMANN. No, sir.

Mrs. WOODEN. There are many doctors who have expressed a notion that total physical examination for very young people or people right up to the age of 45 have not really proven to be truly beneficial healthwise, and certainly not necessarily cost efficient. There has been a great deal of concern over the true value of these physical exams.

I don't have any specific statistics to refer you to or any specific person. I know this is a generalization that we have gleaned from reading other people's works.

Mr. ROGERS. Yes.

Mrs. WOODEN. So, that was some of the reasoning behind this exclusion.

Mr. ROGERS. What about immunization.

Mrs. WOODEN. Immunization? You are talking about, I presume, baby care and polio and things like that?

Mr. ROGERS. To avoid the measles.

Mrs. WOODEN. Baby care and things like that, like you say, they are excluded here but at the same time we do support the concept of preventive care, and it is not something that we are wholeheartedly opposed to.

Mr. ROGERS. Because you know we have statistics showing that in the last rubella incident affecting some 30,000 people, it cost the Nation some $2 billion.

Mr. SONNEMANN. I can agree with that. I retired as chairman of the March of Dimes for the city of New York, and this is a very important program in that whole area and we personally support immunization to prevent malformed babies.

Mr. ROGERS. I think it could be helpful, and I just wanted to inquire about it.

Your bill would go into effect when, if it were enacted say in 1976?

Mr. SONNEMANN. According to its terms, July 1, 1976.

I should say parenthetically, sir, the implementation of the bill may take longer than that. We said July 1, 1976, but I think realism has to take over. It is doubtful in December 1975 that all of these things could be made available and could be in operating condition, but the idea is to get the coverage effective and if that can be done, October 1, 1976, fine, but that again is a matter of practicality.

Mr. ROGERS. Could you give us an estimate of the cost of the bill?

Mr. SONNEMANN. Yes, it has been estimated—and we have not updated these costs recently, but the cost estimates originally were—in the vicinity of $4 billion, $4.2 billion, I think, incremental costs. However, that was before the lapse of controls, and we do not have——

Mr. ROGERS. Updated.

Mr. SONNEMANN [continuing]. An updated estimate on that.

Mr. ROGERS. If that could be furnished for the record, I think it would be helpful.

Mr. SONNEMANN. We will see what we can do.

[The following letter was received for the record:]

CHAMBER OF COMMERCE OF THE UNITED STATES,
Washington, D.C., December 15, 1975.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Health and Environment, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is a supplement to National Health Insurance Testimony by the Chamber of Commerce of the U.S. before the Subcommittee on Public Health and Environment of the House Committee on Interstate and Foreign Commerce, December 9, 1975.

In response to your question regarding the costs of the National Health Care Standards Act, S. 2644, the actuarial study done in 1974 showed an increase of $4.3 billion in government outlays for providing health services. Attached is the actuarial cost estimate that was rendered at that time by Mr. Gordon Trapnell, Consultant Actuary [not printed].

The new bill has some minor technical changes which would not have any significant cost impact. However, since the original cost analysis was made, we have an entirely different economic situation in health care, especially since the lapse of the Cost of Living Council controls on health services.

We are planning to update the cost estimate of the National Health Standards Act in 1976. We will be happy to send you the results.

In response to your question regarding civil penalties for employers who fail to comply with the requirements of this health plan, please note Section 608(a) of S. 2644 which specifically outlines the penalties as follows:

"PENALTIES FOR NONCOMPLIANCE

"Sec. 608. (a) In any case in which the appropriate State official has found, after notice and opportunity for a hearing to the employer, that the employer is not making available to his employees a health care plan which complies with the requirements of this title, he may, after making such efforts as he finds appropriate to secure the employer's voluntary compliance with this title, request the State's Attorney General to bring suit in the district in which the employer designates as his principle place of business, to compel the employer to comply with the provisions of this title.

"(b) Any employer who willfully and knowingly fails to adopt an approved health care plan as required under this title—

"(1) may be assessed a civil penalty of not more than two times that amount such an employer would have spent, in any period not longer than the most recent twenty-four month period, had such employer complied with the requirements of this title; and

"(2) shall reimburse all employees for actual expenditures for health care made within twenty-four months of the date the expense occurred, that would have been reimbursed by an approved health plan had the employer been in compliance with this title."

Please feel free to call on me any time to provide further explanation of S. 2644, or for any assistance in your deliberation of these difficult health issues.

Cordially,

ROSE P. WOODEN,
Economic Security, Education and Manpower Section.
Associate Director

Mr. ROGERS. If you could, let us know your estimate of what a premium would be.

Mrs. WOODEN. In the neighborhood of $400.

Mr. SONNEMANN. I think a little larger than that. I think the realistic cost of this program would be somewhere in the neighborhood of $450 to $500 a year, roughly $40 a month or a little over.

Mr. ROGERS. Of course, you do recommend, as I recall, perspective budgeting for hospitals?

Mr. SONNEMANN. Yes, we certainly do.

Mr. ROGERS. What about approval of those budgets? Who actually would give a final approval?

Mr. SONNEMANN. I think the community planning arrangement has——

Mr. ROGERS. The planning group?

Mr. SONNEMANN. The planning group in the local community and the State are going to have to give approval of these budgets.

Mr. ROGERS. So, it would go up pretty much as envisioned?

Mr. SONNEMANN. Yes, sir.

Mr. ROGERS. By the State?

Mr. SONNEMANN. Yes, sir.

Mrs. WOODEN. Federal guideline.

Mr. ROGERS. With the Federal guideline?

Mrs. WOODEN. Yes, sir.

Mr. ROGERS. I think your bill requires employees to pay 50 percent?

Mrs. WOODEN. Yes, sir.

Mr. SONNEMANN. That is not strictly correct. We say that the maximum contribution of an employer mandated by law is 50 percent, but the bill implies that if the employer wishes to pay all then he may do so, but this is a voluntary matter.

Mr. ROGERS. That would be all that would be?

Mr. Sonnemann. As a matter of fact, most of the large corporations in the country are now paying 100 percent of the premiums for health insurance.

Mrs. Wooden. We put in this 50 percent primarily for the small employer who has traditionally not paid anything toward the cost of health insurance for his employees. If he were hit with the total bill, it would be a severe hardship on him. We felt for the small employer or for the——

Mr. Rogers. I think your mandate a requirement that the employee accept?

Mr. Sonnemann. Yes.

Mr. Rogers. You think we should require them to accept it if it is offered?

Mr. Sonnemann. Yes, and there is a qualification in there. We require him to be covered by the plan, but we do not require him to accept the services if he has legal scruples. There is a difference in those two areas. There are some people whose religion says no, stop.

Mr. Rogers. Is there any reason why you have particularly high cost sharing for obstetrical care?

Mr. Sonnemann. The answer to that is this is based again upon an estimate of cost and experience, and again it is subject to debate and resolution on the basis of practicality.

Mr. Rogers. Could you just point out for us briefly where your bill would improve health resources supply and distribution?

Mr. Sonnemann. I think that the answer to that is we do not address that specifically in our bill.

Mr. Rogers. All right, sir. Are there any other points you would like to mention? I notice Dr. Carter had some questions.

He says you suggested that benefits could be phased in. What priorities would you establish for benefit phase-in and over what time period? Maybe you could submit that for the record.

Mr. Sonnemann. We can submit that, but let me say in general that the basic coverage of hospital, in hospital medical and surgery, are the three things that stand out as being the most necessary, and this is borne out by the purchase of private insurance by 165 million Americans.

Mr. Rogers. Yes.

Mrs. Wooden. We do have provisions for phase-in. These three requirements would be phased in immediately and other benefits would come in over a 5-year period of time.

Mr. Rogers. You might submit that for the record for us, if you could.

Mrs. Wooden. Right.

[The information requested was not available to the committee at the time of printing.]

Mr. Rogers. He also asks why you think employees should be mandated to accept the plan.

Mr. Sonnemann. It has been our experience in industry that if an employee is not mandated, for example, to accept a pension plan, he subsequently stands there at age 65 or at retirement age and made little or no provisions for himself, and he rues the day and it becomes a problem on the employer, so we believe that to get this job done, you mandate the coverage but you don't mandate that they must accept the treatment if they have other scruples.

Mr. ROGERS. What civil penalties would apply for employer noncompliance?

Mr. SONNEMANN. We have provided in the act, sir, that the employer would be liable for noncompliance by having to pay the costs of the hospital and medical and surgical expenses incurred by his employees if he fails to provide their coverage.

Mr. ROGERS. I see.

Mr. SONNEMANN. There is a specific section, programs you could find it.

Mrs. WOODEN. Section 611. Excuse me, that is not it.

Mr. ROGERS. That can be submitted?

Mr. SONNEMANN. We will submit that.

[See letter dated December 15, 1975, p. 213, this hearing.]

Mr. ROGERS. Finally, could you tell me how the bill provides for any long-term care or if it does? Is that problem addressed?

Mrs. WOODEN. It provided that we do have extended care facilities, that the patient would be treated in an extended care facility if it were prescribed by his physician. If it was, he would have to be put out of the hospital for the 3 days and then be put into an extended care facility.

Mr. ROGERS. Must he first go into a hospital before he could be put into an extended care facility?

Mrs. WOODEN. Yes. Then he would have to be out of the hospital for 3 days before prior to being placed int he extended care facility.

Mr. SONNEMANN. There is a prior requirement of hospitalization.

Mr. ROGERS. Yes. Should that be?

Mr. SONNEMANN. I think.

Mr. ROGERS. Does that increase the costs of delivery of care?

Mr. SONNEMANN. Yes, it does. There is no question about that. This mandate again may be eliminated by saying that if his doctor would prefer an extended care facility as distinct from hospitalization, this might very well be a cost containment. We are not adament on that point.

Mr. ROGERS. As I understand you, your long-term care coverage is not phased in for 5 years. What do we do now during that period of time?

Mrs. WOODEN. During the transition?

Mr. ROGERS. Yes.

Mr. SONNEMANN. Let me put it this way. It is not the intent of our bill, and if the result of what we have said is that there would be a hiatus of coverage, we would not recommend that. There has to be a continum there were coverage is substituted one for the other.

Mr. ROGERS. Thank you.

You have been most patient with the committee. We are grateful to you for being here. Your testimony has been very helpful. Thank you for appearing and for this testimony.

The committee stands adjourned until 1:30 tomorrow afternoon.

[Whereupon, at 5:30 p.m., the committee adjourned, to reconvene at 1:30 p.m., Wednesday, December 10, 1975.]

NATIONAL HEALTH INSURANCE

Major Proposals

WEDNESDAY, DECEMBER 10, 1975

House of Representatives,
Subcommittee on Health and Environment,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:30 p.m., in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. Rogers. The subcommittee will come to order, please.

We are continuing our hearings on the various national health insurance proposals. We are very pleased today to have as our first witness one of our colleagues who has taken a most active interest in the area and has introduced legislation. The committee is very anxious to hear his thinking, Hon. Andrew Young of Georgia.

We welcome you to the committee and your statement will be made a part of the record in full [see p. 219]. You may proceed as you desire.

STATEMENT OF HON. ANDREW YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Young. Thank you very much, Mr. Chairman.

I don't want to take the time of the committee unnecessarily.

I would just like to say the bill (H.R. 6283 [1]) that we have put together is attempting to blend very well into what this subcommittee has already done. You have provided through the Health Planning Act and Health Manpower Act for the planning and construction of health facilities as well as for the training of health care personnel.

Our bill uses the trust fund mechanism to provide for the delivery and financing of health care services for patients.

When I first came to Congress I got a physical examination from the Capitol physician, and he gave me this wonderful little card, with my electrocardiogram and medical record to keep in my pocket, it dawned on me that if this was good enough for Members of Congress why not for the people who send us here. By doing these kinds of diagnostic tests in advance and develping a preventive system of health care, and by taking the added feature of putting some numbers on this card like a BankAmericard or American Express card we would have the mechanism through which health care could be charged and delivered across State lines. With the development of computer technology and so forth it's now technically possible to develop the system of financing and a system of health care delivery which can meet the needs of every American citizen.

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[1] See p. 969 for full text of H.R. 6283.

In our approach, we try not to radically change the present delivery system but build in incentives so that those aspects of health care delivery which work best might begin to get the most work. This kind of health credit card, which might send its fund into a national health care trust fund, the patient might choose between a fee for service method, or a preenrolled relationship with a particular physician or join a health care group or relate to a neighborhood comprehensive health center.

Nothing in our bill would mandate radical changes in the practice of medicine by Government fiat.

It would be done on the basis of the patients' freedom to choose those forms of health care delivery which best meets their needs. If they find that the fee for service method is not giving them the kind of services that they might get in a comprehensive health center, for instance, they would be able to enroll in that comprehensive health center.

The funding for this bill would be basically payroll taxes, 2 percent for employees, 6 percent for employer, 5 percent on unearned income, with no limits, and that plus the taking over of the existing taxes which I understand are about to be increased, on cigarettes, alcohol and firearms, would make up the basis of a trust fund. I understand that the Ways and Means Committee is anticipating increasing those taxes on cigarettes and alcohol anyway, and at the existing rate it would prove to be about $7 billion contribution toward a health care trust fund.

Mr. Chairman, I think what we are doing now is providing health care for the poor and elderly, and it's proposed that we can provide health care for the unemployed and also for catastrophic illnesses.

I would contend that if we did that we would end up with a $75 billion package, and we still would not be covering the health needs of the citizens who are paying for it. Rather than taking a piecemeal approach of adding on to the existing health care legislation, that we in this Congress, move ahead with a comprehensive health insurance plan.

Frankly, I don't think that the other body would get one out, and if they did, it would probably be vetoed, but it's going to take a couple of years to get any kind of system in motion, and I would think that if we had a good bill to begin to coalesce American opinion where we could profit by some of the cost overrun problems of medicare and medicaid, that we would be able to produce a bill which would be workable at least by the next Congress.

So I would commend the chairman and this committee not only for these hearings but for the work that you have done in health planning facilities and health manpower.

I come from the South, I am particularly concerned about the distribution offices, especially in the rural areas, and I think that with funding variable where the people are that we might have an additional incentive for the dispersal offices, that physicians tend to go where the money is, but under this plan every health care consumer in America would have an allotment of somewhere around $500 and a physician then could organize a health care practice to meet those needs. Preferably on a preventive basis, because he would make more money if they stayed well than he would make if they got sick.

Presently our health care system rewards the doctor when his patients get sick, and there is something very un-American about that, that if we could reward the physician for keeping the patient well, I think we would be moving in the direction of a more equitable health care delivery system.

Finally, our plan would not do away with the role of private insurance companies, at least not for 10 years, and that it would still be possible for any businesses or any groups of a thousand or more to subcontract their health insurance needs into the insurance company of their choice which would then be plugged into the health trust fund, as I think you now do with medicare or medicaid.

[Congressman Young's prepared statement follows:]

STATEMENT OF HON. ANDREW YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Chairman, I appreciate the opportunity to testify on a matter which I believe ranks at the highest level of priorities in the Congress: the issue of providing comprehensive health care for the American people.

I commend you and the Committee for holding these hearings. Your are providing a forum for a constructive dialogue which could lead to legislation for a sound, humane, effective program of health care for the nation—which would be a monumental achievement.

In this dialogue, I hope that we can proceed from the concept that health care is a right, that it can and must be available to every person in this country.

The bill I have introduced, H.R. 6283, is designed to fulfill this right. At this point, I would like to submit for the record a detailed comparative analysis of this and other health care bills which are before your committee.

Mr. Chairman, let me begin this assessment of health care as an issue by stating my belief that the American people today, by an overwhelming majority, support a substantial revision of our health care system.

In a recent nationwide poll, the Cambridge Research Institute found that, although the public generally favors some trimming of the federal budget, in the category of health care, people support an expansion of government services. Among the findings of this poll by Mr. Patrick Caddell were the following:

Only 13 percent supported "keeping things as they are today."

Twenty-three percent favored "a small system where poor people are given medical insurance and everyone is protected against major illness."

Thirty-five percent wanted "a system of national health insurance which guarantees every person as much care as he or she needs."

Twenty-two percent endorsed "a totally nationalized system where not only is everyone guaranteed as much health care as he or she needs, but doctors and hospitals are taken over by the government and the prices are regulated."

Our nation is the only major industrialized country in the world that does not have a national system of health care for its people. Although we're Number One in military power, we have lagged far behind other countries in such areas as infant mortality and life expectancy.

I do not mean to suggest that when it comes to health care, this is a totally heartless nation. We do have programs for the poor and aged. Dedicated health professionals are providing highly skilled services in many parts of the nation. Some employer-employee plans provide a comprehensive range of health care services. American medical science has had a role in finding ways to treat and cure major diseases.

The problem, as I see it, is threefold: First, there is not enough preventive health care. It is tragic when a pregnant woman, because of lack of pre-natal care, gives birth to a child with permanent brain damage. Or when hypertension goes undetected and leads to a stroke or heart attack.

Second, we need to improve the delivery of health services. We must make health care more accessible in rural areas and in the cities.

Third, only a relatively small number of people in the United States have the truly comprehensive health coverage that everyone needs and deserves.

Let us consider, for example, the coverage provided by private health insurance. A study by the Library of Congress reports that about three out of every four Americans in 1973 had some form of private coverage against the costs of inpatient hospital care. But only 33.5% had coverage against the costs of physician's services in the office or at home. Insurance for drugs was held by 59.8% of the population; 58.7% had coverage for visiting nursing services; 10.4% had some form of dental insurance.

Overall, private health insurance accounted for 41% of all consumer expenditures for personal health care. The rest came from the consumer's pocket or the government.

What is left out of these statistics is, of course, the health care that was not delivered—because health facilities or professionals were not immediately available, or because the person was unaware of the need for diagnosis or treatment.

Fortunately, in the Congress and among health professionals, there is an emerging consensus that some kind of national health insurance is inevitable. Spokesmen for the American Medical Association have confirmed this. And Medical World News, in its issue of March 10, 1975, reported that in a nation-wide poll of physicians, 56.2% favored some form of national health insurance.

As we consider legislation, it seems to me that we would do well to remember that comprehensive care for all can be provided without vast increases in what is already spent on health care.

The U.S. Department of Health, Education and Welfare has estimated that the American people in fiscal year 1975 spent approximately $103 billion for personal health care. That is the combined total of private and public expenditures.

Last year, HEW examined various health care proposals before Congress—bills which are similar to those now before this Committee, from the so-called AMA bill to those with comprehensive care for all—and found that total health care spending, if any of these programs were enacted, would not greatly change the total already being spent.

All of the bills would require some increase. But we should remember that we are not talking about spending $100 billion or more in additional money, because we are already spending that much on the existing health care system.

It seems reasonable that we can afford a very modest rise in health care expenditures, when the Congress is being asked to approve a military budget in peacetime in excess of $100 billion, and when we are presented with a plan to subsidize the energy industries to the tune of $100 billion in new dollars. Let us give less priority to destruction and corporate subsidies, and greater priority to healing and people.

What would change significantly if we had a national health care plan is the way funds are raised to provide for health care, and who would get which services.

On the question of funding, my view is that it makes sense for people who are working, their employers, and individuals receiving unearned income to pay for health care, year by year as income flows in, through a direct tax received by an independent Social Security Administration. Essentially, that is prepaid medical care.

There exists already an unnecessary fear of a mythical government intervention in the practice of medicine. Medical care is a business, and a legitimately profitable business. The government is already heavily involved in health care. Doctors have very substantial earnings under Medicare and Medicaid.

The government has a critical role in the building and funding of hospitals, providing aid for medical and nursing students, and providing care for the aged and indigent. In fiscal year 1975 federal, state and local government provided $39.2 billion for the nation's health bill. An 8% slice of the federal tax dollar pie went for health care.

Finally, there is the all-important matter of what services are to be provided, and to whom. As for recipients of the benefits, I return to the concept that health care is a right of all human beings. We need the best possible revised system of health care, and it seems to me that "the best" by definition, means all services required for the maintenance of good health and the treatment and cure of illness or disability.

Some items, such as non-critical cosmetic surgery, need not be covered by a natinal plan. But people do need to visit doctors, go to hospitals, take prescription drugs, obtain hearing aids and eyeglasses, receive mental health care, use laboratory facilities and special medical equipment. And what they truly need should be provided.

A comprehensive system can be devised, in my judgment, without sacrificing the freedom of either doctors or patients. It can be a system which requires high professional standards and provides incentives for such needs as expanded services in rural areas and comprehensive neighborhood health centers in our cities.

National health insurance is an issue which is so important that all sectors involved should participate in the discussion—consumers, health professionals, public officials (particularly those in the health field), medical educators and scientists. A rational dialogue can lead us to a workable, fair and effective system to serve the future generations of Americans.

Mr. Rogers. Thank you very much for a very helpful statement and for submitting your plan for the consideration of the committee.

Mr. Maguire.

Mr. Maguire. Congressman, some people who agree with the general approach of your bill, and that would include myself, are concerned that the enactment of this or the Corman bill, or some such approach, will add substantially to the Federal budget in costs and perhaps aggravate the deficit, at least, this is the concern many people have expressed.

I wonder if you would comment on that, both in terms of the numbers as you understand them, the total increased cost to the budget plus impact on deficit, and where you think we ought to come out on that question in relation to the need.

Mr. Young. I think really what we are doing in fact is not spending new dollars, we are taking over $100 billion now being spent on health care through private and public means and bringing the money under one umbrella.

So really it's a reorganization of the financing of health care with the same amount of money that is being used now, approximately.

I would think that in a few years that would actually decline since the high cost of health care is largely hospitalization, and that with the incentives reversed we could do things on a preventive basis and probably lower the number of instances of hospitalization.

But I think that that is one of the areas where frankly I have got to do more work. I don't know, we have not had time to do detailed studies, for instance, of the reasons for the cost overruns in my own State of Georgia.

My casual observation is that the programs went out without clearly defined guidelines.

We use the phrase routine dental services in my bill. I don't think we ought to let each dentist define what routine dental services are. I think we ought to take the time to carefully spell out the kinds of dental services that ought to be a right.

I don't think that, for instance, orthodontia ought to be a right unless there is an instance of such severe deformity, the difference between amalgam filling and a gold filling.

We ran into cost overruns because people insisted that they didn't make any distinctions. I have got gold fillings on one side of my mouth and amalgam fillings on the other side of my mouth and they both chew the same at one-third, one-fourth the cost of the other, but it doesn't make any difference.

I think defining the services very carefully in a bill is one of the ways of building in a kind of cost control.

Also in our bill we have an area planning group which is made up in our bill largely of consumers. There would be 15 persons in a health planning committee, an area planning committee. Only 5 of them would be health care professionals and 10 would be consumers. And that the responsibility for the cost controls on an area basis would be in part supervised by that kind of grouping.

Mr. MAGUIRE. Am I right in thinking that one of the differences between your bill and the Corman bill is that your bill, as you explain, increases the collections from the employers and employees sufficiently to cover the entire cost, whereas 50 percent of the cost under the Corman bill is drawn from the General Treasury?

Mr. YOUNG. That is correct.

Mr. MAGUIRE. And presumably that has an impact on the deficit under the Corman bill?

Mr. YOUNG. On the Federal deficit it does.

Mr. MAGUIRE. Whereas yours does not?

Mr. YOUNG. That is right.

Mr. MAGUIRE. But there is the tax credit provision.

Do you know what the loss of revenues would be under the tax credit provisions? Has that been tracked out?

Mr. YOUNG. No; I don't know that. But the progressive feature about this tax deduction method is that the unearned income—there is no limit on the amount. I think the Corman bill also has the limits set above which people are not taxable. This has no limits.

Mr. MAGUIRE. Thank you.

Mr. ROGERS. The full committee is in session for the moment. We must go down to help make a quorum.

The committee will stand in recess for 5 minutes.

Would it be convenient for you to wait for us to return? There may be a few questions.

Mr. YOUNG. I am at your pleasure.

Mr. ROGERS. The committee stands in recess for 5 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I want to congratulate the distinguished gentleman from Georgia on his statement. I think it's a very comprehensive statement and highly idealistic.

I should like to ask a few questions. I see it's 2:32; is that correct?

Mr. ROGERS. That is what I have.

Mr. CARTER. Thank you, Mr. Chairman.

I ask my distinguished friend, in financing this we have a 5-percent tax on unearned income and self-employment earnings; is that correct?

Mr. YOUNG. That is correct.

Mr. CARTER. All right, 2-percent payroll tax on employees' wages; right?

Mr. YOUNG. Right.

Mr. CARTER. And a 6-percent tax on employers' payrolls; is that correct?

Mr. YOUNG. That is correct.

Mr. CARTER. All right, what do we have now on employees and employers as social security?

Mr. YOUNG. I am afraid I don't know offhand.

Mr. Carter. It's a 5.85 for each, as I understand it. That would be 11.7 percent. We add to that 6 percent and 2 percent and we get about 17.7 percent; do we not?

Mr. Young. If you say so.

Mr. Carter. There is a breaking point beyond which we can go. It has been estimated that if social security rises much higher that the already overburdened system will go into deficit—further deficit than it has right now—and this is one troublesome feature of this legislation, I would say to my distinguished colleague.

Now, in going over the provisions of your bill, which is very fine, very idealistic, as I see it, you mention preventive medicine. Where is that included in your bill and how would you——

Mr. Young. Well——

Mr. Carter [continuing]. Suggest——

Mr. Young. It would be included because for the physician there are three of four possible ways they could practice. He could practice either on a fee for service basis, in which case there would not be much in it for preventive medicine; but if there was a prepaid plan with the individual physician, that physician would receive an allotment of approximately $500 to keep that patient well.

We are already beginning to see this. I think for the first time in some 20 years of going to doctors we were shocked when my wife received a letter from her physician asking her to come in for a check-up.

Under this kind of plan it would encourage that kind of advance checking up with the same kind of computer terminals that are available to our offices for about $200 a month.

A physician could put his entire patient load in a computer bank and communicate with them on a regular basis.

Mr. Carter. He would be given $500 for each patient?

Mr. Young. Approximately; that is the way it divides up.

Mr. Carter. And there are 215 million people in this country, and if you will multiply that by half of a thousand, we arrive at, let's see, that would be $107 billion.

Mr. Young. Yes.

Mr. Carter. For preventive medicine?

Mr. Young. No; for all kinds of medicine.

Mr. Carter. I see.

Mr. Young. Which is about what we are paying now.

Mr. Carter. Well, really, we are paying more than that in a sense.

Mr. Young. Yes.

Mr. Carter. But much of this is going to medical schools and for different programs. Would you want, my good friends, to discontinue any of these programs that we have or would they all of necessity be revamped?

Mr. Young. One of the reasons they come before this committee is because of the work that you have done in the area of health manpower and health facilities and that, what I think my bill does, is add a delivery system to this and creates a kind of cabinet level operation for health care over the Nation.

Mr. Carter. Thank you for the extra minute, Mr. Chairman, and thank you, Mr. Young, for a very good statement.

Mr. YOUNG. Thank you.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

I just want to commend Mr. Young for his contribution to this whole dialog and debate on national health insurance.

I have always found him not only to be a humane and compassionate man but also a very practical man, and without going into a lot of questions right now with a seamless web it's hard to ask one question without opening up a tremendous field.

I hope we draw on his wisdom as we move along in this dialog. I think your bill is certainly going to be a great help and it will make a real contribution to our discussion.

Mr. YOUNG. Thank you.

Mr. ROGERS. Mr. Scheuer?

Mr. SCHEUER. I want to join in commending our colleague, Congressman Young, for the great effort and diligence and creativity that went into putting together this measure.

As Congressman Preyer just mentioned, this area is a seamless web and I don't suppose what we will come out with 6 months from now is going to be identifiable as anyone's bill, but I am sure there will be golden threads running throughout the bill that you will be able to identify as a product of your thought and your imagination.

I have two questions. First, the credit card business. I guess we all have had problems with credit card companies, American Express and you name it, sending us bills that are full of snafus; they overcharged us, undercharged us, they didn't get our new address, they rendered us inoperative, nonpersons.

Have you consulted with anybody who has told you that we have the technology to really run a computer base credit card system for the whole country, 210 million people in one agency?

In other words, do we have the technology to operate a nationwide medical billing system?

Mr. YOUNG. I haven't really consulted with any of the experts in the field. There is a member of the faculty at Emory Medical School, which has taken this credit card system a step further in that the computer base facilities are available so that when your credit card goes in anywhere in the country your diagnostic records are available to that physician.

So I would suspect that the technology will not be as much a problem as the politician.

Mr. SCHEUER. You may be damning it with faint praise when you say that.

I know that LEAA is working on a system whereby every police car in the United States would have a little plate and if a suspect is apprehended by a policeman his palm can be placed on that plate and it will be connected with a central computer bank in Washington and within 2 or 3 seconds there will be a little printout right in the police car that indicates whether that man has a prior record and whether he is wanted in any jurisdiction anywhere in the United States.

I have the feeling what you are taking about is within the realm of the possible, but I wondered if you have any specifics for us.

Mr. YOUNG. If I could say, Mr. Chairman, there is really nothing particularly new and creative here. We kicked around some ideas and tried to see what we could do but then somebody told us that President Harry Truman had made some statements about health care and we went back and checked on them and found out that in about 1943 as a Senator he introduced a bill that was almost the same concept and that some of the things that have been kicking around in the legislative halls for all that time are still with us and I hope that we can get them out and make them available to the American people.

Mr. SCHEUER. Can I ask the gentleman one more question very briefly?

Mr. ROGERS Yes.

Mr. SCHEUER. I have spent sometime in England talking to their national health people and the one thing they regret is that they started out with a system that they described as free. They have had a great deal of trouble controlling over-use of the system, frivolous use of the system, and they say anywhere from half to two-thirds of the people who come in, particularly the elderly people, have really nothing wrong with them and burden the system unfairly so that the people who really have medical problems have to que up and wait for weeks and months.

I see that you reject coinsurance and copayment on the part of the insurers.

Do you have any ideas as to how under the kind of a program which you outline we can avoid silly frivolous use of the system, and discourage overutilization?

Mr. YOUNG. The only thing I would think is that in a group health plan you would have paraprofessionals, health paraprofessionals that might give preliminary——

Mr. SCHEUER. Screening?

Mr. YOUNG. Screening services, and clearly defining which services are available. Those are the only two things I have thought about.

Mr. SCHEUER. Well, I just want to congratulate the gentleman on a very fine contribution he has made and we appreciate it very much.

Mr. YOUNG. Thank you very much.

Mr. ROGERS. May I say, I join in those sentiments. I may have some questions I would ask you to answer for the record if you don't mind.

Mr. YOUNG. Sure.

Mr. ROGERS. Also, could you give us again the overall cost of your plan?

Mr. YOUNG. Well, I think the plan as we had it updated would run something like $94 million but that would not include the military. It would take over medicare and medicaid, everything but the Veterans' Administration.

Mr. ROGERS. I see.

And the benefit packet is a total packet?

Mr. YOUNG. It's a total packet.

Mr. ROGERS. Including dental and——

Mr. YOUNG. We say routine dental service and a limited number of mental health psychiatric outpatients.

Mr. ROGERS. Twenty visits, 40 visits, do you recall?

Mr. YOUNG. I think we had 50 visits but I met with a group of psychiatrists in the district. What I have been trying to do is get health professionals themselves to define what they feel to be a legitimate description of the psychiatric services that ought to be rendered.

I have got a group of dentists that are supposed to define specifically routine dental services and I would like to bring those definitions in to the committee.

Mr. Rogers. We would appreciate that.

[The information requested was not available to the committee at the time of printing.]

Mr. Scheuer. A great deal of very fine work has been done in the delivery of mental health services by para-professionals and I think this may be a part of the answer so far as mental health is concerned.

Mr. Rogers. When would your bill go into effect if we were say, to, enact it next year, how long would it be?

Mr. Young. It would be 2 years.

Mr. Rogers. Two years after that?

Mr. Young. Yes, sir.

Mr. Rogers. And, as I understood it, you basically use the payroll tax for payment?

Mr. Young. But I would certainly bow to the wisdom and experience of this committee. I have no claims of authorship. I just wanted to get the people in my district involved in thinking about health care and use this bill as a vehicle for doing that.

Mr. Rogers. It's been most helpful and you are kind to be here to allow the committee to share your thinking.

Thank you so much.

Mr. Young. Thank you.

Mr. Rogers. There is a vote on the floor that is not making the committee's hearing go quite as smoothly as we might like, nevertheless, we will have to recess again for 10 minutes while members cast their vote.

The committee stands in recess and then we will take up the next witness, Congressman Lagomarsino.

[Brief recess.]

Mr. Rogers. The subcommittee will come to order, please.

Our next witness is our distinguished colleague from California, Hon. Robert Lagomarsino.

We are delighted to have you before the committee. We know of your interest, and your statement will be made a part of the record in full and you may proceed as you desire.

STATEMENT OF HON. ROBERT J. LAGOMARSINO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Lagomarsino. Mr. Chairman and members of the committee, I welcome this opportunity to speak on behalf of H.R. 3252.[1] I consider this a unique opportunity, for I realize that in recent months the attention of the Congress has turned away from the need for a national health insurance bill. One of the primary reasons for this is that in these days of great national economic strain, few would seriously consider adding further costs to Federal Government, and to the taxpayers we represent. Therein, however, is the importance of this bill, for we feel it would not add to the cost of Government, but can deliver the service at no additional initial costs and reflects continued savings when compared to any known system of nationally administered health insurance.

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[1] See p. 635 for full text of H.R. 3252.

The inception of H.R. 3252 came from my constituent, Mr. Peter Fisher. A resident of Santa Barbara, Mr. Fisher is the author of a book, "Prescription for National Health Insurance." His studies of the British Columbia health insurance system led him to the conclusion that an adaptation of that system could benefit the United States. Such an adaptation, geared to the needs of Americans, is provided by this bill which I cosponsored with my California colleague, Congressman Bill Ketchum.

H.R. 3252, provides a practical, proven method for delivering basic total hospital and medical protection to every American at less cost than that now being spent for partial coverage under existing programs. In addition, the free enterprise concept of private practice by physicians, and independently operated hospitals, is preserved in this bill.

In brief, the insurance plan provided for by H.R. 3252, would establish a public corporation that would offer voluntary enrollment to all U.S. residents. The benefits available would be 100-percent medical and hospital coverage (including psychiatric treatment).

The bill as now written provides there would be no copayment, deductibles, limits, or exclusions for medically necessary service, including in-hospital oral and podiatric surgery. Additional benefits, if feasible, might be added later.

The Health Insurance Agency envisioned in this bill would replace all medicare, medicaid, and CHAMPUS programs, which would then be terminated.

An outstanding feature of H.R. 3252, is that all claim and enrollment procedures would be simplified, when compared to those currently used, and administrative expenses would be limited by law to 3 percent of the plan's income. Basic to implementation of this latter feature is the fact that the plan pays for available services from existing physicians and hospitals. In no way would the plan be used to supplant existing physicians and hospital services, but would indeed encourage the expansion of same.

Monthly premiums, under the plan, would be related to family income, ranging from a low of $3 per adult, and $1.50 per child, minimums, to $15 per adult, and $7.50 per child, maximum. It is estimated that the average premium would average out at $9 per month, for a total of $108 per year. These user premiums would be matched by Federal general funds.

Under the method provided for in the bill, an estimated annual savings of $23 billion would result, when compared to the present costs of medicare, medicaid, and CHAMPUS. In 1974 it was estimated that it cost $12.39 simply to process each medicare claim. During the same year, in British Columbia, and under the philosophy which we have incorporated in this bill, the total administrative cost (not just the claim-processing cost) was 46 cents. That kind of economy, warrants your very close consideration of H.R. 3252. The continuously spiralling costs of our three present systems, at a time when both individual and national economic considerations cry for efficiency and economy in all

Government programs, make H.R. 3252 a particularly attractive alternative to more costly proposals.

As I see it, the main advantages of H.R. 3252 are four:

(1) Because of the size of the U.S. population, and the low administrative cost experience cited above, there would be a relatively low cost to the subscribers. The cost to the Federal Government is below the cost of the current systems.

(2) The simplified system of operation and administration envisioned in the bill would be a benefit to the subscribers, doctors, and hospitals. (How this would work is covered in point 9, of the attached summary.)

(3) The plan does not mix Federal moneys and private companies, as several other proposed plans do.

(4) The plan contained in H.R. 3252 could solve the problem of ever-rising malpractice costs. It would do this because voluntary subscription would permit mandatory arbitration as a condition of enrollment. This would greatly reduce the cost of malpractice defense. Such current costs have become a built-in tax on the medical bills of millions of Americans.

Hearings of this committee are a necessary first step in examining the many alternatives for solving the problem of adequate health care, at reasonable cost, for all Americans. This mode, on which H.R. 3252 is based, is working for the residents of British Columbia. Although I realize changes might have to be made for it to operate as well for our citizens, I urge the committee to fully and thoroughly explore my proposed alternative before making a final decision.

It may well be, Mr. Chairman and members of the committee, that that is not the answer but it does seem to me in my limited study of the problem and of the plans that have been proposed that this plan at least warrants very careful consideration by the committee and by its staff and I would certainly welcome the committee's investigation.

[The summary referred to follows:]

SUMMARY: THE NATIONAL VOLUNTARY MEDICAL AND HOSPITAL SERVICES INSURANCE ACT, 1975

Introduced in the 94th Congress by Reps. William M. Ketchum and Robert J. Lagomarsino (*Based on a proposal in the book Prescription for National Health Insurance by Peter Fisher*).

1. The objective of this bill is to make total medical and hospital protection available to every American at *less* total cost than is being spent now, under a system that would preserve the complete independence and integrity of the medical profession while eliminating most of the present paperwork and administrative expense of existing public and private health insurance programs that now pay more money to fiscal intermediaries and other non-productive middlemen than is paid to physicians. It is estimated that this bill would reduce current public and private insurance management costs from more than $20-billion a year to less than $2-billion, thereby making more money available to pay for health care and giving doctors more time to attend to patients. This bill would *reduce* State and Federal budgets, rather than increasing them as required by all other national health insurance proposals now before Congress.

2. This program would pay 100% of all necessary medical and hospital care, with no limits, deductibles, exclusions or copayments. (Out-of-hospital drugs and dental care not covered)

3. Premiums would *average* $9 a month per person, ranging from a minimum of $3 for adults and $1.50 for children to a maximum of $15 for adults and $7.50 for children, depending on family income; totalling $21-billion per year for 200-million enrollees. Premiums would be matched by Federal general funds, creating a total fund of $42-billion. There would be no special payroll taxes and present Social Security taxes would be reduced.

4. Present Medicare, Medicaid and CHAMPUS medical and hospital benefits would be ended, thereby saving $23-billion a year in State and Federal expenditures now providing partial coverage for less than 50-million persons or less than 25% of the population.

5. Enrollment in the Plan would be 100% *voluntary*. State and local governments could pay $3 monthly premiums for welfare recipients and employers could pay premiums for employes. (*Compulsory* premiums or payroll taxes on individuals or employers would convey a *right* to expect and demand medical care whenever and wherever wanted; this would place excessive demands on doctors and ultimately require government allocation of services or "socialized medicine". Under a *voluntary* system: "no service, no premium")

6. Insurance Plan would be offered by new Federal Agency on the open market in competition with present private commercial and non-profit insurance or prepaid health plans.

7. Participation voluntary for doctors but mandatory for approved hospitals/nursing homes.

8. Agency would set fees for all medical services but individual doctors could charge their patients reasonable extra fees if justified or to control unnecessary demands for service. Hospitals paid "actual costs" but all new capital expenditures would require Agency approval.

9. All claims by doctors and hospitals would be submitted on standardized 3″ × 7″ computer punch card invoice forms and paid automatically within 45 days, subject only to clerical audit and without individual assessment of medical validity.

10. State medical societies or P.S.R.O.s would be solely responsible for policing all utilization of insurance benefits by patients and providers, through periodic review of total billings and profiles of practice (*not* on a claim-by-claim basis). Providers found to be chiseling would have their future payments reduced or suspended.

11. If available funds were depleted by chiseling or excessive billing by *some* providers, fees and rates payable to *all* providers would be reduced. (Congress would retain absolute control over the total budget, with future premiums and matching funds being increased only for actual increases in the costs of medical and hospital services, *not* for unwarranted utilization by patients or providers.)

12. 35% of premiums and matching funds would be reserved for medical service, sufficient to pay 225,000 physicians an *average* of $65,000 a year each, if 200-million persons enrolled in Plan. (At present, there are about 200,000 M.Ds. in office-practice in the U.S., averaging about $60,000 a year in fees.) 62% of funds would be reserved for hospital and nursing homes: $27-billion for 200-million enrollees or $134 per capita.

13. All administrative costs (including payments to medical societies or P.S.R.O.s for utilization review) would be limited by law to 3% of premiums and matching funds.

14. All enrollees would be required to submit any claims for alleged malpractice/negligence in insured services to an arbitration panel of the Agency and all awards would be paid by the Agency, subject to recovery from responsible providers or their insurance. This procedure could potentially reduce present malpractice defense costs by about $4-billion a year or nearly 10% of all present direct and indirect medical and hospital costs.

15. Availability of low-cost voluntary insurance would quickly define those inner-city and poor rural areas in which fee-for-service health care is *not* likely to be available, thereby justifying establishment (outside of the insurance Plan) of higher-cost HMOs or Community Health Centers for residents who could not benefit from the insurance.

A STATEMENT OF THE CONDITION OF HEALTH INSURANCE IN THE UNITED STATES, 1974

(By: Peter Fisher, author of "Prescription for National Health Insurance")

This is the system that the Administration, the American Medical Association and Health Insurance Association of America want to "preserve" and "build on" for any National Health Insurance program. (Data sources: HEW/SSA Bulletin 2/75; AMA census of physicians, 1973; HIAA testimony to Congress, 1974; IRS statistics extracts, 1972.)

Estimated population with some public or private health insurance coverage	190,000,000
Estimated total public and private personal health care expenditures (civilian)	$90,300,000,000
Total government (Federal/state/local) health expenditures (medicare, etc.)	34,000,000,000
Health benefits paid by Blue Cross-Blue Shield	11,000,000,000
Health benefits paid by commercial insurance companies (HIAA)	10,000,000,000
Health benefits paid by nonprofit union, fraternal and community plans	2,000,000,000
Total health expenses paid by all public and private insurance	57,000,000,000
Total health expenses paid "out of pocket" privately by patients	$33,300,000,000
Estimated total employees in HEW medicare and medicaid administration	25,000
Estimated total employees in State and local medicaid program administration	125,000
Estimated total employees in Blue Cross-Blue Shield plans (BC–BS figures)	70,000
Estimated total employees in commercial health companies (HIAA figures)	500,000
Estimated total employees in non-profit union, fraternal and community plans	5,000
Estimated total employees in medicare/medicaid "fiscal intermediaries"	25,000
Estimated total employees in all public and private insurance administration	750,000
Estimated total cost of all health insurance administration on basis of salary, expense and capitalization at $25,000/year/employee (750,000)	$19,000,000,000
Total administrative cost as percent of benefits ($57 billion) paid	1
Total physicians in office-based practice (AMA census, 1973)	200,000
Total hospital-based resident and staff physicians (AMA census, 1973)	62,000
Total physicians in direct patient care	262,000
Estimated total gross fees of office-based MD's at $60,000 average (200,000)	$12,000,000,000
Estimated total salaries of hospital-based MD's at $35,000 average (62,000)	$ 2,000,000,000
Ratio of insurance employees to physicians (750,000: 262,000)	3 : 1
Ratio of insurance employees to insured persons (750,000: 190,000,000)	1 : 253

Comment.—The above figures show that three persons are employed in public and private health insurance administration for each physician who is partially paid by health insurance; and that the total cost of administering health insurance is $5 billion more than the gross income of all physicians in direct patient care in the United States.

Comparative Statement of Condition of Health Insurance in British Columbia, Canada, 1974

Total population covered by hospital and medical insurance plans	2, 500, 000
Total hospital service plan budget (including administration)	$277, 000, 000
Total medical services plan budget (including administration)	180, 000, 000
Combined hospital and medical budget (95 percent of all hospital/medical costs)	457, 000, 000
Combined hospital and medical plan administrative costs (actual)	$10, 404, 794
Combined administrative costs as percent of combined hospital/medical budget	2.2%
Total administrative employees in hospital and medical services plans	950
Total office and hospital-based physicians in direct patient care	4, 100
Ratio of insurance employees to physicians (950 : 4,100)	1 : 4.3
Ratio of insurance employees to insured population (950 : 2,500,000)	1 : 2,630

Mr. Rogers. Thank you so much for a most helpful statement. The committee will consider your proposal very carefully, and we will go into the details of the British Columbia system as you suggest.

Mr. Lagomarsino. Thank you.

Mr. Rogers. I am grateful to you for bringing this to the attention of the committee.

Dr. Carter.

Mr. Lagomarsino. As I said, Mr. Chairman, I don't pretend to be an expert. I am sure there are many questions that you may have about the details how it would work, and I think it would probably save time and would be more beneficial if you have those kind of specific questions if they would be directed in writing and I can try to——

Mr. Rogers. Yes, thank you.

Mr. Carter. I want to thank you, Bob, for a very good statement. We appreciate it very much.

Do you have any idea or could you include for the record the cost of this particular program?

Mr. Lagomarsino. Perhaps we should include that for the record, which I will be pleased to do. Some of that is attached.

Mr. Carter. Would it be in the neighborhood of $107 billion?

Mr. Lagomarsino. No; I think it would be far less than that. As I understand it, under the present system total health expenses paid by all public and private insurance at the present time are $57 billion. The Government is spending about $23 billion. So we are talking about $80 billion. So if we do succeed in supplanting all of those other programs the cost would be somewhere around $80 billion.

Mr. Carter. That would include funds for medical education, nurses' training, and things of that nature, too?

Mr. Lagomarsino. No, it would not include that.

Mr. Carter. That would be above that?

Mr. Lagomarsino. Yes.

Mr. Carter. In addition to it?

Mr. Lagomarsino. Yes.

Mr. Carter. Could you describe a bit more the arbitration board which would be established for patients' malpractice claims?

You can include that in the record.

Mr. Lagomarsino. Yes.

Mr. Carter. We will discuss it some time later.

Thank you so much.

Mr. Lagomarsino. Thank you, sir.

Mr. Preyer.

Mr. Preyer. Thank you.

I want to commend you also. I think this is the way hearings are supposed to work where you have a lot of ideas bubbling up from all over the country.

Mr. Lagomarsino. Put them on the table.

Mr. Preyer. It's good to hear about the British Columbia system.

I will just ask you one question.

Have you discussed with any members, or has Mr. Fisher, as far as you know, discussed with any members of the medical profession the feasibility of establishing the kind of detailed fee schedules that your bill would require?

Do you know what the doctors' reaction to that is?

Mr. Lagomarsino. All I can say is, well, I have heard more about this bill in this concept than other people because that is where Mr. Fisher lives and he has made speeches and talks and had newspaper articles and so on, the doctors in Santa Barbara seem to feel that it would be workable, that it has worked, I am told, I haven't gone to British Columbia myself and studied it, but I have been told it worked quite well there.

The figure I heard was some 98 percent of the people there who were eligible to enroll are enrolled and they seem to be fairly happy with it.

Now, on the other hand I think it's apparent 2.5 million people in British Columbia is far different than 200-plus million in the United States where we already have a number of plans.

So it would be a different situation but I think that it is the kind of plan that is certainly worthy of very close consideration because there is a model, it has worked there, apparently.

Mr. Preyer. Thank you very much.

Mr. Lagomarsino. Thank you.

Mr. Rogers. Thank you for your presence. We will probably be in touch with you as we go along.

Mr. Lagomarsino. Thank you.

Mr. Rogers. The committee must recess for 5 minutes for a quorum for the full committee. We will be right back.

Thank you for your patience.

[Brief recess.]

Mr. Rogers. The subcommittee will come to order, please, continuing our hearings on national health insurance. It is a pleasure for the Chair now to recognize one of the most active members on the Hill who is a member of the full committee and has taken an active interest in matters of the subcommittee and has been most helpful in perfecting our legislation, the Honorable John Murphy of New York.

We welcome you to the committee.

STATEMENT OF HON. JOHN M. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Murphy. Thank you, Mr. Chairman.

I would ask that Dr. Max Parrott and Mr. Harry Peterson join me here at the witness table.

Mr. Rogers. We welcome them at the table.

Mr. Murphy. Thank you, Mr. Chairman. I would like to congratulate this subcommittee on moving ahead through these frenetic days when there are four-ring circuses going on. I would like to particularly thank our committee which is so involved in this critical legislation and moving forward with an issue that is so vital to the American people.

My purpose here today, Mr. Chairman, is to introduce practitioners and representatives of the field of medicine. Their organization, the American Medical Association, designed the national health insurance program which will be the topic of discussion this afternoon. I cosponsored the plan because I believe that the legislative process should be open to all responsible and workable national health insurance proposals. The importance of national health coverage cannot be overstated. For the benefit of our citizens, all plans should receive equal consideration and review.

This bill, H.R. 6222, was submitted by the Nation's physicians. Who could be more qualified to discuss and present options in the field of national health care than those men and women who have made the U.S. medical services the best in the world? For me, this plan makes sense as it targets in our major questions confronting our Nation's health service and the ability of our health programs to deliver equitable and high quality care. Let me just mention three of the issues addressed by this legislation.

First, this legislation would provide for a uniform health insurance program for our Nation's poor. This is done by offering full, federally funded health insurance programs for those people of low-income status. The proposed program would roughly equal the benefits offered by current Federal employee programs.

Second, this bill would require that part of the financial obligation of the program be borne by the private, rather than the Federal sector. This provision requires that an employer make available and contribute toward the cost of a comprehensive health insurance plan for employees and their families. This is accomplished by the employer paying at least 65 percent of the premiums for the chosen health plan. Such a procedure would be equal to or better than the current Federal employee health program.

The added advantage to this provision is the fact that the cost to the Federal Government for its implementation would be zero. A small business would, of course, be relieved by a subsidy if the 65-percent provision proves to be a burden. Those who are self-employed would also be covered under this legislation.

The third major factor addressed by this legislation is what I believe to be one of the most salient issues in the area of health today—the question of the financial implications of catastrophic illness. With the enactment of this legislation, no American will ever again be devastated by a prolonged family illness. The tragedy of serious illness is enough for a person or family to bear without the knowledge that the price of that illness may amount to annihilation of life savings and total bankruptcy.

In some capacity, this plan provides health insurance coverage to every citizen yet costs considerably less than other responsible proposals. Especially today, when our Nation is experiencing the worst financial difficulty in decades, we must be prudent. I believe this program should be considered a viable and appropriate choice among those national health insurance proposals currently under consideration.

Now, it is my pleasure to introduce Dr. Max Parrott, president of the American Medical Association, and Mr. Harry Peterson, the legislative director of the American Medical Association, who are prepared to speak at length on the proposals which I have addressed.

Thank you.

Mr. Rogers. Thank you very much, Congressman Murphy, for your kindness in being here, and in introducing our next witness. Your statement is most helpful to the committee.

We are grateful to you for your presence and your interest.

Mr. Murphy. I would appreciate the opportunity to depart to the full committee for the rail markup.

Mr. Rogers. Certainly, thank you so much.

Dr. Parrott, Mr. Peterson, we welcome you to the committee and would be pleased to have you proceed. Your statement will be made part of the record in full [see p. 240] and you may proceed as you desire.

STATEMENT OF MAX H. PARROTT, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION

Dr. Parrott. Thank you.

Mr. Chairman, I will be reading from a summary. The full statement I think has been submitted to the committee.

I am Max Parrott, M.D., president of the American Medical Association. I am a practicing physician from Portland, Oreg. Accompanying me, as indicated by Congressman Murphy, is Harry N. Peterson, director of our department of legislation, from Chicago.

We are happy to be here today and we are grateful to Congressman Murphy for his introduction. We agree with him, we also think the health care system in this country is the best in the world.

It's not a perfect system as it now stands but it gets better from year to year.

As you receive testimony on national health insurance you will hear from advocates of vastly differing proposals as to the structure of national health insurance.

This question poses one of the important issues relating to that subject.

What form should a national health insurance program take?

We feel it should address itself to the problem of providing comprehensive health benefits to every American regardless of his ability to pay for them.

We believe that basic and catastrophic protection can be made available to all persons, without throwing fiscal prudence to the winds. And we suggest that the method for accomplishing this goal is embodied in the Comprehensive Health Care Insurance Act of 1975, H.R. 6222.

There is another consideration that is germane to your deliberations:

Realistically, in considering what any national health insurance plan is expected to accomplish, the inherent limitations of any plan must also be recognized.

Mr. Chairman, this is not idle speculation. Consider, for example, that no proposed national health insurance attempts to answer many problems which have a profound and immeasurable impact upon health: housing, nutrition, personal hygiene, education, accidents, lifestyles, and personal habits.

Until these problems are solved, no program can go beyond a certain point in remedying national health problems.

These vital problems affecting health cannot be alleviated by medical remedies.

However, some plans are offered as panaceas capable—among other things—of assuring health security. Their sponsors assert that their program alone can improve our health and will cut dramatically into the infant mortality rates and, just as dramatically, add years to the human life span.

No matter how sincerely the claim is made, it cannot be accepted. You would in reality get more results from the same taxpayer's dollar if you banned alcohol and tobacco and imopsed lower maximum highway speed limits.

Therefore we must all bear in mind that the only viable purpose of a national health insurance plan should be to provide access to personal medical care.

And that's what we think the Comprehensive Health Care Insurance Act of 1975 would do. This bill— H.R. 6222 [1]—is the culmination of an evolutionary process based on the national health insurance proposals that have been offered by the AMA since 1969 and introduced into each succeeding Congress. Each of these proposals has sparked extensive debate and discussion focusing upon the proper role of a national health insurance program.

During the period of beneficial discusson many advancements have been made in our health delivery system.

As the subcommittee knows, we have beefed up our manpower programs, built more health facilities, and registered a substantial increase in private health insurance coverage.

H.R. 6222 takes these and other improvements into account.

But let me preface a discussion of how we are to move further forward with a brief assessment of where we are now.

How far have we come without national health insurance? What are the strengths of our present system?

First, we have the best medical technology in the world.

Second, we are graduating more physicians from medical schools than at any time in our history. Approximately 13,000 doctors will graduate this year—up 72 percent since 1965. Of great significance is the fact that it has now been established that 58 percent of the 1974 graduates have entered training programs in medical specialties considered to be primary care.

Third, we've opened more medical schools in the past 10 years than we did in the previous 20. We now have 114 as compared with 88 in 1965. Many of these new schools emphasize primary care and are located in areas of physician shortage.

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[1] See p. 927 for full text of H.R. 6222.

Fourth, basic health insurance policies now cover 80 percent of our total population. The private sector also provides catastrophic benefits for 3 out of 4 Americans.

These are some of our present strengths, Mr. Chairman. We must recognize them as such. Any national health insurance plan that does not build upon them would be as unsound as a blueprint for a skyscraper that provided for no foundation.

Meanwhile, we are so close to overcoming our manpower shortages that manpower surpluses are being predicted in the near future. We are experimenting with alternative delivery systems. Increasingly, we are using new types of health care providers.

So we are not standing still during this period when national health insurance is being studied.

But as I said before, weaknesses do exist in our present system.

The most immediate problem is the one of financial access.

Advanced medical technology is expensive. Health care costs continue to rise. And the state of our economy adds to the problem.

No American should be denied medical care because he cannot afford it. For some, however, medical care is not readily available because their insurance is inadequate to cover the costs of basic and catastrophic benefits.

All of us know such cases. And all of us agree that we must act to prevent their occurrence.

This is precisely what H.R. 6222 would accomplish.

The first word in the bill's title is "Comprehensive." It is an accurate description of the benefits this proposal would cover:

All inpatient and outpatient hospital care; 100 inpatient days in a skilled nursing facility; all home health care services; full physician services, including all medical care provided under a physician's direction; a full range of preventive services, including physical examinations, immunizations, and inoculations; well-baby care, X-ray and laboratory services; ambulance services; full psychiatric care; dental services for children under age 7, with that age limit raised each year until all under the age of 18 are covered; and emergency dental care.

These benefits would be identical for all persons.

Everyone—regardless of income—would be protected not only for basic benefits, but also for catastrophic expenses of illness.

As to the operation of our program, I would first like to direct your attention to the largest segment of our population which would come under our bill.

Most Americans are presently covered by employment based insurance, the premium on which is either paid in full by the employer or shared between the employer and employee.

The total cost of this insurance is therefore paid within the private sector. Why, then, should tax dollars be used to pay for protection already financed effectively through the private sector?

We see no point in it. So our bill simply mandates the employer to offer coverage for employees and their families. It requires that full coverage be provided and that the employers pay at least 65 percent of the premium.

It is important, I think, that what we propose continues the kind of protection with which we are already familiar. This translates into an ease of operation because of familiarity with, and similarity to, presently existing insurance programs.

Employee participation would be voluntary. And for those small businesses on which the mandate worked some economic hardship, financial assistance would be provided.

As for the self-employed, they would be covered equitably by another section of the bill.

The employed and self-employed have a choice of private coverage, whether it be an insurance policy, or Blue Cross-Blue Shield plan, a group prepayment plan, including a health maintenance organization, or any other plan meeting the program's standards of adequate coverage. The unemployed and the poor would have the same range of choices.

For the unemployed and low-income person the Federal Government would help pay the premium. The amount of the Federal contribution would be scaled according to the income of the insured.

In the case of the low income, the Government would pay the total premium. And on the same basis Federal participation would help medicare eligibles to obtain supplemental coverage sufficient to raise their benefits to the level provided in the new plan.

Simple mechanisms built into the program facilitate the Government's premium participation without resort to a cumbersome means test.

A premium participation table enables the individual to assess readily the amount to which he is entitled. He may buy his insurance, pay the full premium, and claim the Government share as a credit against tax on his income tax return. Or, he may arrange to pay only his share of the premium—if any—prepare a claim form, and have the carrier bill the Government for the premium balance.

Let me mention, in passing, the shortcoming of the present medicaid program. Medicaid ill serves the wealthier States and fails miserably to meet even a minimum level of health needs for the poorer States that can't find the matching dollars.

One effect of our program, therefore, would be to set high national standards of health benefits for all persons in every State of the Union; and for the poor it would pay for the full array of benefits with Federal dollars.

H.R. 6222 is, we think, a financially prudent plan. It would not qualify as one unless it included financial safeguards. They include cost-sharing through coinsurance.

Although the amounts are small, cost-sharing between the citizens and the Government would help keep the cost of the total program at a reasonable level.

Coinsurance would be 20 percent of the cost of all covered benefits with the limit related to income. The poor would pay no coinsurance. Furthermore, in no case would coinsurance exceed $1,500 for an individual or $2,000 for a family—regardless of income. For as soon as an individual or family reached the limit on coinsurance, the catastrophic portion of the plan would take over.

Mr. Chairman, I realize that a number of other national health insurance proposals have been presented—or will be presented—before the subcommittee.

In previous testimony before Congress we have discussed the more important ones in some detail, and if it would be useful to your purpose, we would be happy to furnish you copies of what we have said.

Our full statement submitted today carries a discussion of our opposition to H.R. 21, the Health Security Act; H.R. 1, the National Health Care Service Reorganization and Financing Act; and H.R. 10028, the Catastrophic Health Insurance and Medical Assistance Reform Act.

But for now, I think it would be more appropriate and helpful if I devoted the balance of these oral remarks to some basic observations which bear directly or indirectly on your present studies.

First: Catastrophic insurance—however appealing it may be—is only the very tip of the iceberg representing financial need. It assures peace of mind for everyone; but fewer than 1 percent of all Americans run up medical expenses of more than $5,000 in any year. For most, then, the catastrophic occasion will never occur. The major need remains access to full, across-the-board care.

Second: No national health insurance program would solve all health related problems because of provisions relating to preventive health care. Those who say it would do so are guilty of naivete or overpromise. Nothing I can do, or my colleagues can do, for example, will stop patients from smoking, overeating, drinking too much, or hating their jobs. Adequate housing is disease preventive. So is clear air.

To repeat; national health insurance would provide insurance against costs; it would not, in and of itself, assure a healthy nation.

Third: One of the main reasons why people are properly concerned about the high cost of health care is the direct result of medicine's success in the development of new technology.

Individuals live longer today because of better medical technology. We can save more and more of the seriously ill, or the badly injured, because health personnel are more skilled than ever before in history; and because we have at our disposal remarkably sophisticated and complex equipment.

The equipment is expensive. So is the training of health personnel. And so are health facilities, which must necessarily comply with present statutes and regulations aimed at assuring quality care, and which face the rising costs of labor, equipment, and supply.

Bearing these things in mind, Mr. Chairman, the problem more clearly emerges as one of financing and administration. Nothing argues in favor of restructuring the entire system, turning it over entirely to the Federal Government, and abandoning the every solid underpinnings of a delivery system that is already—right now—delivering the highest quality health and medical care available throughout the world.

As to financing, some of the proposals before you would increase social security taxes significantly to pay the bill. As the subcommittee is certainly aware, we are at a point where many people are paying a higher social security tax than an income tax.

An alternative method of paying for national health insurance would be to keep the bulk of the financing within the private sector—a method that demonstrably works—and seek whatever new taxes are needed from the general revenues.

As for how national health insurance should be administered, again there are differences of opinion. Some suggest that the Government should handle the administration, largely through the Social Security Administration. We differ with them.

We believe the administration of a successful national health insurance plan should be kept within the private sector, where the overwhelming bulk of health insurance is now administered.

National programs which are the prototypes for some of the proposals now before you surely furnish convincing evidence that government administration tends to create as many administrative problems as it solves.

However, we need not rely solely on our experience in this country. We need only to look abroad, where European national health insurance programs are held up to us as shining examples of what we, in the United States, should be doing.

We would do well to look, for thereby we might learn.

When the central governments of these European nations undertook the responsibilities of financing and administering their national health insurance plans, overall progress became "frozen" at the point where Government assumed control. Hospitals and other health facilities slipped gently into obsolescence and moved from there to the antiquated.

Health personel began leaving, to the point where emigrations became a steady exodus.

The waiting lists for treatment have grown longer, to the point where patients wait a year or more for admission to a hospital. Governments, faced with the mounting dissatisfaction of patients and providers, tried to ration health care in the futile effort to control costs. In this, they were partially successful—but only at the price of reducing quality.

And I remind the members of the subcommittee that the nations of which I speak are—by comparison with the United States—compact, small and homogeneous.

By contrast, ours is a huge, sprawling, heterogeneous nation whose health problems differ widely from local to State to regional levels.

We have thus far dealt with this diversity—and successfully—by keeping our system flexible, by accepting the continuing need to innovate, and by recognizing that there is always more than one way to reach our goal.

Because we have not been confined to the rigidities of a government-designed mold, we have been able to apply differing solutions to diverse problems. In a word, our system has been pluralistic.

It is a composite of private initiatives and public programs. And it has worked well.

Mr. Chairman, let me repeat a statement we made last year in testimony before another committee of the Congress. We said—and I quote:

> The fact is that more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in the history of this country.

The truth of that statement is unassailable.

The system is not perfect. But it is improving and can be improved further. It is a system that is flexible, innovative, pluralastic and—on the whole—a strong and successful one.

Let us build on it, not dismantle it. And toward that end, let us address ourselves to the considerable task of tearing down whatever financial barriers may stand in the way of Americans and the quality health care they need.

We commend H.R. 6222 to your consideration as the health insurance program best suited to meeting our national need.

Mr. Chairman, we will be pleased to respond to any questions the subcommittee may have. Again, let me express our appreciation for the opportunity to appear before you and to express our views.

[Dr. Parrott's prepared statement and attachments follow:]

STATEMENT OF MAX H. PARROTT, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the subcommittee: I am Max H. Parrott, M.D., President of the American Medical Association. I am a practicing physician from Portland, Oregon. Accompanying me today is Harry N. Peterson, Director of our Department of Legislation.

Mr. Chairman, we are pleased to have this opportunity to appear before you to express our views on national health insurance. The subject of this legislation has been raised many times during the past three Congresses. Once again national health insurance is under close scrutiny by interested Congressmen, Committees, Administration officials, and the public.

The extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact upon society.

We have observed a shift in attitude concerning such a national program. There is an increased awareness and concern on the part of most interested parties as to the magnitude of the problems involved. These problems have been brought into better focus as a result of evidence of the effects of governmentally administered and controlled programs both here and abroad.

Our national priorities have also shifted during that time because of the changing economy and the devastating effects of inflation on all segments of our society.

The public has expressed among its major priorities a concern with inflation, with the state of the economy, and with crime. National polls have indicated that national health insurance is of relatively low concern.

During this same period of time significant changes have taken place in our health system through increased manpower programs, increased facilities construction, increased levels of private health insurance coverage, and a variety of other programs. There is fuller realization and acknowledgment that this country's system—under attack by many in the course of the NHI debate—is indeed superior to any other in the world.

Mr. Chairman, we will amplify on these points in our statement.

In the past few years, a great many proposals for national health insurance have been introduced in the Congress, all with a common claim of increasing the availability of health care to all Americans regardless of income. Many volumes are filled with the testimony of advocates and critics of the various plans submitted, and countless appeals have been made before committees of the Congress and in public forums urging the adoption of one plan or another.

In pressing for the adoption of any particular proposal, however, sincerity must not be confused with objectivity. We cannot afford to have a program of such importance fail.

The health care system in this country is a pluralistic one—a composite of various private initiatives and public programs. It is a system which encourages innovation and competition by providing incentives for organizational change and offers opportunity for improvement of quality care.

Improvements in our health system are continually occurring, and the system is increasingly effective in responding to the needs of our society. We therefore urge deliberation and caution in considering any national health plan. The public interest would be better served if we examine the goals in NHI within the context of the existing system and direct our energies toward perfection of this system. It is unnecessary to gamble on a whole new medical health system, whose effects and efficiencies in the main are unpredictable, in order to meet the health care needs of all Americans.

COMPREHENSIVE HEALTH CARE INSURANCE ACT (H.R. 6222)

We offer our plan for maximum health services for all persons through comprehensive insurance protection under a proven system which provides the finest health care in the world, one which can be financed in the private sector with a minimum of federal support. This is the "Comprehensive Health Care Insurance Act of 1975" (H.R. 6222).

H.R. 6222 would establish a program to assure that every person has equal access to high quality medical and health care regardless of ability to pay. For the poor and the affluent alike it provides identical coverage and includes protection against both the ordinary and catastrophic expenses of illness that an individual or family might encounter.

Coverage would be provided for all inpatient and outpatient hospital care, 100 inpatient days a year in a skilled nursing facility, and all home health care services. It also provides: full physician services, including all medical care provided under his direction; a full range of preventive services, including physical examinations, immunizations and inoculations; well-baby care; x-ray and laboratory services; ambulance services; and full psychiatric care. Children under age 7 will be fully covered for dental care, and this age limit will be raised each year until all persons under the age of 18 are covered; adults would be covered for emergency dental care.

Cost-sharing will apply as a safeguard against abuse, but will apply in moderation so as not to deny benefits to persons in need of care who cannot meet such costs. There is no deductible in our plan—no fixed amount is required to be paid before benefits begin. Benefits will begin immediately; coinsurance is set at 20% with a limit based on income. However, there is a ceiling as to the amount of coinsurance that any individual or family will be required to pay in a year. The poor, however, will not pay any coinsurance.

Most Americans are currently covered by employment-based insurance, and the premium is paid in full by the employer or shared between employer and employee; the total cost is thus paid in the private sector, and without government involvement. H.R. 6222 mandates the employer to offer coverage for employees and their families, thereby continuing a method of protection with which they are all familiar and which can be readily put into operation. The mandate gives legislative assurance that the full coverage will be provided, that the employer will pay at least 65% of the premium and, accordingly, that the employee will have only a limited participation in the premium cost.

Those who are unemployed or poor will be entitled to federal participation in the premium, but they—like all others—will still have a choice of private coverage—an insurance policy, a Blue Cross/Blue Shield plan, a group prepayment plan (including HMO), or any other plan meeting the program standards of adequate coverage. The amount of federal contribution would be scaled according to income of the insured—and the government would pay the full premium for the poor. On the same basis, federal participation would assist Medicare eligibles in obtaining supplemental coverage to bring their benefits up to the level contemplated in the new insurance program.

Simple mechanisms built into the program facilitate the government's premium participation without resort to a cumbersome means test. A premium participation table enables the individual to assess readily the amount to which he is entitled. He may buy his insurance, pay the full premium and claim the government share as a credit against tax on his income tax return. Or he may arrange to pay only his share of the premium, if any, prepare a claim form, and have the carrier bill the government for the premium balance.

Most Americans believe that the role of government financing in health insurance should be directed toward making quality care accessible to those who cannot afford to meet the expenses of such care. This is an underlying precept in our program of private insurance through employment—financed primarily in the private sector—and premium assistance by government for the poor and the elderly.

Public opinion, as adjudged in various polls, does not perceive medical service to be a major problem area. This is the substance of independent polls which have identified inflation and our economy as our nation's most serious problem; health care rated next to last of 16 concerns with only 2%–3% of the respondents placing emphasis on this. Inasmuch as any of the proposals for extensions of federal subsidies for medical service is inevitably inflationary to some degree, one wonders about the advisability of further aggravating this most serious problem in order to attack a problem of much lesser magnitude.

If, in the view of Congress, an urgent need for national health legislation exists, we commend for your specific approval H.R. 6222, which would preserve the flexibility of our medical system, and build on the real accomplishments of American medicine. It stresses the major contribution made by the private sector of the economy and takes advantage of private institutions and industries. It attempts to hold to a minimum its demands upon government, both for tax dollars and for the inevitable controls that go with them, and does not thrust upon the government a tremendous program of health spending to be financed primarily through new taxes.

We see, on the other hand, in some of the other proposals now before the Congress, elements which threaten the existing system of health care delivery and the high quality of care it affords. We shall touch on only a few of these.

PUBLIC UTILITY CONCEPT

We strongly oppose a public utility approach to health care delivery as conceived in H.R. 1. Newly created entities—Health Care Corporations (MCC's)—would be operating under franchise of the State Health Commission (SHC), in designated areas within a state, and would provide services directly or through affiliates within their franchised areas. Each SHC would be under mandate to divide the state into HCC areas and blanket the state with HCC's. The SHC would also have rate making authority. In addition to the special federal subsidies for the development and operation of HCC's, provision is made for special premium subsidies for HCC enrollees. In the interest of good medical care, we have advocated a policy of pluralism which affords an individual or family a variety of health care delivery methods, and a choice of the kind of care they will receive. We reject as undesirable and unnecessary the state franchising of health care operations and public utility regulation. We also reject the discriminatory federal funding which provides preferential treatment in support of a single method of health care delivery.

Highly objectionable also is a provision in HR 1 which specifically requires that services of certain physicians (such as radiologists and pathologists) be paid as hospital services, thus making them subject to the institutional rate making provisions. Any plan should properly recognize the physician's professional service as being distinct from hospital services, and any provisions for institutional reimbursement should not be interpreted to include the professional services irrespective of the setting in which the professional services are provided. This differentiation from hospital services should apply to physicians' services under any bill, including H.R. 6222.

FREE-STANDING FEDERAL CATASTROPHIC INSURANCE

H.R. 10028 (identical with S. 2470, the Long-Ribicoff Bill), emphasizes catastrophic coverage. Revised from its form in the previous Congress, it now provides in part for the use of private insurance, and in this respect we are pleased that it does indeed recognize one of the strengths in our present system.

However, the total program contemplated in H.R. 10028 is unacceptable. This is a program of only catastrophic insurance—with benefits for medical services to begin after a family has incurred $2,000 of medical expenses, and for hospital care benefits to begin after 60 days of hospital confinement. Coverage would be provided either under a public plan, administered in parallel with Medicare, and subject to Medicare conditions and limitations on payment of services, or under an elective employer plan providing private insurance for employees and their families. Such private coverage would be administered by the carriers. Underlying the public plan for catastrophic insurance would be basic coverage for low-income persons under a federalized Medicaid program administered in the same manner as Medicare and financed from federal general revenues and state contributions. Providers and practitioners would be required to accept as reimbursement in full for their services only those amounts designated as payments from the plan.

In examining the need for such a program we observe that, in 1974, 135 million persons under age 65 had major medical insurance. This is the most rapidly growing form of health insurance in the nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal federal program of free-standing catastrophic insurance.

We believe that benefits under any health care program should be comprehensive. H.R. 6222, which we support, recognizes that catastrophic protection should be a part of total comprehensive benefits, which include both basic and catastrophic protection. Free-standing catastrophic coverage is made to appear attractive because it requires less financing, but this is because it is a program of very limited benefits and makes no provision for the fundamental health care needs of the majority. Catastrophic insurance alone is not a solution to the problem of meeting the health care problems of all persons. For this reason we have opposed such a measure.

There are additional objections to H.R. 10028 which we might point out, however. For one, the proposal will operate to enlarge the sphere of federally financed and controlled insurance coverage while severely reducing insurance in the private sector. Under a system of HEW certification of private insurance, private carriers will be induced to tailor their policies to provide basic coverage with limits adequate to meet only the deductibles contained in federal catastrophic insurance. This will have the net effect of transferring insurance coverage from the private section to the tax financed public program. It is easy to observe, moreover, that further government invasion into the insurance field may be achieved through the simple device of reducing the catastrophic insurance deductible.

Complexities in present federal insurance administration will be compounded as different conditions and methods of payment become applicable with respect to the individual who has basic private insurance and government catastrophic insurance. The insured as well as the health care provider may not learn until after the services have been performed whether such services will be reimbursable under the coverage and conditions of the private carrier or the government plan. The complexities of the bill will cause needless confusion.

In the same vein, there are ominous implications in the fact that methods of reimbursement will differ according to whether an employed person is covered for catastrophic insurance under an employer plan or under a public plan with its specific reimbursement limitations. We must object to a further extension of the unfair and arbitrary Medicare reimbursement levels for physician services.

In our concern for erosion of the present health care system, we must look upon this program as an incremental approach to complete governmental domination of the health care system. The danger is real, and with any accession of bureaucratic control the course of complete dominaton becomes more difficult to reverse.

The American citizen, as both patient and taxpayer, would be ill served by transferring the functions now performed by the private insurance system to a federally controlled and operated system.

SOCIAL SECURITY PLAN

H.R. 21, the Health Security Act, would establish a program to be administered by a 5-member Health Security Board approved by the President and to be financed by new social security taxes and matching funds from general revenues. The Board would divide the country into regions and establish within the regions health service areas with local offices and branches. All providers of health care services—professional practitioners, institutions, laboratories, among others—wishing to participate in the program would have to enter into contracts with the federal government and be bound by specified conditions. All health services would be provided within a fixed budget.

The Budget would be established annually by the Health Security Board and could not exceed estimated receipts from the special taxes and matching funds from general revenues.

Funds budgeted for services would be divided among regions throughout the country. Regional funds would, in turn, be divided among health service areas established within the regions. Allocations would be made for each of the following classes of services: institutional services, physician services, dental services, drugs, appliances, and other professional and miscellaneous services. All services within a class would have to be provided within the level of the budget provided. Every employer would pay a 3.5% payroll tax, wage earners would pay a 1% tax on salary; and self-employed persons would pay a 2.5% tax. The employer tax would apply on total payroll. The tax base for salaried persons and the self-employed would be 150% of the old-age benefits tax base. The amounts collected by these taxes would be matched by general revenues.

We disagree with the use of a Social Security tax as a financing mechanism for health insurance. A Social Security tax is regressive in that it imposes a disproportionate burden upon the poor and the middle class wage earner. This results irrespective of how the respective employer-employee share of the tax is divided.

Furthermore, a federally administered program as that conceived in HR 21 has no basis for assuming that it could be better or more economical than administration in the private sector. In fact, the record of programs administered by government—both by ours and by others—provides little evidence to support the belief of government capacity in such an important program.

We must avoid the mistake inherent in proposals such as H.R. 21 which would lock medicine into a rigid, monolithic, no-choice bureaucratic system. Such a creation would be impossible to reverse. It would be an undertaking full of promise but empty of fulfillment. Establishment of cost control through fixed budgets including arbitrary fee schedules would result in curtailment of care and discourage participation by providers. A look at the current trouble of the British health care system impels a close re-examination of the alleged need for such drastic action as is embodied in H.R. 21. In our opinion justification for such a program is totally lacking.

In addition H.R. 21 would impose on our tax system—already strained—the burden of some $50 billion in new social security taxes and the matching from general revenues of an additional $50 billion in order to support a federally controlled and administered health care system under which all services would be supplied by providers and professional practitioners under contract to the government.

There is no basis for assuming that health care financing can be better or more economically administered in the governmental sector than in the private sector. On the contrary, government administration has been shown to be more costly. We agree with a former Secretary of HEW that elimination of the profit factor, through the Social Security handling of health insurance finances, will not bring economies and efficiencies; the financing of health care is too important to the American people to turn over to a federal bureaucracy.

GENERAL COMMENTS

Mr. Chairman, at this time we would like to review with you some of the points to which we alluded briefly in our introductory remarks, to express some of our major concerns in NHI legislation, and to call attention to some of the accomplishments which have taken place within the present system in recent years.

First, American medical service and medical technology have developed at an unparalleled rate, along with American scientific achievement in general, since World War II. Presently in this country there is more and better medical technology than anywhere else in the world. And that technology has been fostered and achieved in the absence of a national health insurance program.

Second, there are more physicians being graduated from medical schools at this time than at any other time in our history. The estimated number of graduates for this year is nearly 13,000, a 72% increase in 10 years. In addition, approximately 58% of those entering graduate medical education (specialty training) are now in medical specialties considered as primary care—a goal which was not expected to be achieved for several years (see attachment 1). This is being accomplished in the absence of national health insurance or federal controls.

Third, more medical schools have opened in the past ten years than were opened in the previous twenty years. We now have 114 medical schools as compared with only 88 in 1965 (see attachment 2). Many of these schools are emphasizing primary care and are located in non-metropolitan or physician shortage areas. This, too, has been done in the absence of a national health insurance program.

Fourth, statistics show that presently the private sector has made available to the population basic health insurance benefit policies covering 80% of the total population. In addition that same private sector provides catastrophic benefits for 3 out of every 4 persons in this country. The bulk of the remaining population has access to Medicare/Medicaid. A very small percentage represents people who, unfortunately, do not now have such insurance. At this point I might add, Mr. Chairman, that our Association strongly encourages the development of realistic private catastrophic insurance coverage and its acquisition by the public. Of significance, we note that while there is an increasing amount of private insurance, the total percentage of health care expenditures for private insurance benefits for the under-65 population has steadily increased from 1966; also total out of pocket personal expenditures (which include premium payments) have decreased during that time. Moreover, this massive private health insurance coverage has occurred without stimulus of a national health insurance program.

It is also necessary to point out that if we had adopted programs similar to those of other countries our present strengths would have been compromised and jeopardized.

Mr. Chairman, these great strengths which we see in the health care system of this country are the ones upon which we believe it is most appropriate to build any program of national health insurance. It is both reasonable and obvious that these aspects must be accentuated rather than adopt a program suggested by some which not only would impose a system of federal administration upon our health system but would also attempt, for some reason still unclear to us, to "restructure" the entire system.

We do, of course, recognize that there are some weaknesses within the present health system. But we would hasten to point out that weaknesses are in the process of being rectified by our present responsive system without the need for a national health insurance program.

Manpower shortages are being overcome (surpluses, in fact, have been predicted for the near future by responsible government officials), alternative delivery systems are under experimentation, new types of providers are being utilized on an increasing scale, greater health education is being carried on by many groups, and new public awareness of the impact of total environment upon health is being aroused.

However, one significant problem which does remain, and which appears to us as a primary concern of the public, is the one of financial access to care, particularly in view of advanced medical technology and increasing health care costs, as well as the state of our economy.

We have all been made aware of individuals, or their dependents, who have need of medical care but who have had inadequate insurance for both basic and catastrophic benefits.

It is this type of example which has made us all fear for the financial consequences of illness. Financial hardships do occur, and provisions must be made for their occurrence. But these occurrences must not be used as the justification for a national program to restructure an otherwise viable, responsive, vital and highly competent system.

As you hear testimony from advocates of those programs which would attempt to restructure the system as well as to provide a financing mechanism, I would urge you to keep in mind not only the foregoing essential considerations, but also the following basic thoughts concerning medical care in America today.

First, the need for catastrophic coverage is to assure that if such expenses do occur the individual will be able to pay from a source other than his own pocket. Nevertheless, this insurance for most people under 65 in reality is only *assurance* for peace of mind since, for most, the catastrophic occasion will never occur. The major need remains access to full care.

Second, preventive health care, touted by many supporters of other bills as achieving a superior state of health if enacted, is limited in its effectiveness under any health insurance program. National health insurance *cannot* correct many conditions leading to serious illnesses and to suggest otherwise amounts to over-promise. For example, how would any physician stop his patient from smoking? What will convince anyone not to overeat or not to pursue an improper diet? Who can be forced to exercise? What will be done to assure adequate housing, clean air, proper working conditions, a healthful environment? What about boredom, indifference, depression, lack of family attachments? Who will stop drug addiction and alcoholism? What about injuries and deaths caused by accidents? We could continue to enumerate many other issues which, whether generally recognized or not, are part of preventive health care and which have a definite, direct bearing upon life styles, quality of life and of health, but which cannot be ameliorated by any national health insurance.

Third, it must be pointed out that one of the very basic reasons for present concern over the high cost of care can be directly traced to the success of medicine in recent years in its development of new technology. The elderly live longer today because of better medical technology. The seriously ill or injured are kept alive and eventually returned to normal life through the intervention of more highly skilled personnel and more complex equipment. Organs are transplanted, and people are able to carry on their lives. Today we treat and maintain the chronically ill and the seriously ill and injured beyond what was even imagined twenty or thirty years ago. In addition health facilities are expensive because of the necessity to comply with present statutes and regulations intended to foster quality care. Labor, equipment, and supply costs are higher. Although some costs might be reduced through a system of strict rationing, we must pose the question as to whether Congress would desire such a system at the expense of continued development and application of medical technology.

All of these points which I have reviewed with you strongly militate against a restructuring of our present system.

With these concepts in mind, I would urge you to look to the fundamental issues in the proposed national health insurance plans—methods of financing and administration.

In these two elements the plans vary considerably.

Some plans would tax payrolls through Social Security taxes to fund a program administered and controlled by Social Security. Others would more realistically rely upon the present strong points in our system by requiring employer coverage and insurance carrier administration in the private sector.

This latter type plan recognizes the important role of the private sector as well as the administrative limitations and shortcomings of Federal bureaucracy. It also recognizes the fact that administration of a national health insurance program is better performed in the private sector. Administration in the private sector is more realistic when one considers the mounting envidence of problems arising in national programs which are prototypes for proposals now advanced involving government administration.

We need only call attention to European national health insurance programs as examples. When their central government took over the responsibilities for financing and administering programs, the growth and development of facilities and technology were "frozen" at the level at which central government took control. Since that time the governments have been faced with increasingly antiquated facilities, with a growing dissatisfaction with the government system by both providers and patients, with an exodus of trained personnel to other countries, with increasing tax liability, with increase in costs, with waiting lists of one or more *years*, and with inability of government to cope wth "rationing" of health care. And it must be remembered that these problems have occurred in countries which are, as compared with the United States, small in area, compact, and homogeneous—factors which should really help to assure success—and where the population is inclined to look to the central government for assistance in many areas.

In our own country, the program which comes closest to an example of a national health insurance program for the public is Medicare—a program which has benefited the elderly. However this program has been characterized by overzealous bureaucratic control. In fact, its method of administration cautions against adopting any such similarly administered program for the general public.

For example, for many of the aged Medicare represents their only insurance protection. The program was, because of rhetoric engaged in at the time of its passage, cast in light of full coverage. Medicare today, however, in fact provides less than one-half of the beneficiaries' health costs. The limitations of the law, together with interpretations by HEW, have restricted payment benefits. In addition, copayments and deductibles which are part of the program have increased annually (e.g., as to the hospital deductible, from $40 in 1966 to $104 in 1976). Part B premiums have also increased.

Providers themselves have been affected by bureaucratic interpretations which have often discouraged provider participation rather than encourage it. Recent improper regulations have included the utilization review regulations, the economic index controls, the MAC impositions and the arbitrary hospital reasonable cost limitations.

If Medicare is the example of what a national health insurance program will become in this country, then we can expect the government, on one hand, to provide a program creating the appearance of a broad and attractive package of benefits, but on the other hand, to limit the benefits by paying less than the true value of services provided, by establishing budgetary limitations on expenditures for all categories of services, by determining patient coverage based on fine lines of administrative regulations, by requiring extensive paper justification of every service, and by allowing administrators to "rewrite" sections of the law.

Is it reasonable to believe that with national health insurance totally administered by the government the same experience will not recur? Is this what the American people really want?

We would further draw your attention to the recently issued report of the General Accounting Office entitled "Performance of the Social Security Administration Compared With That of Private Fiscal Intermediaries in Dealing With Institutional Providers of Medicare Services". The conclusion stated in that study is, in the words of the GAO, expressed in the following:

"GAO compared performance and cost of the Division of Direct Reimbursement with that of four contract intermediaries. It found that the average cost of a bill processed by the Division in 1973 was greater than that of the four private insurance companies. Higher salaries and lower productivity appear to be major reasons for the higher costs of the Division, which, unlike the private intermediaries, had no production standards. Financial reports required of private intermediaries were not required of the Division."

As a final cautionary note, we would urge you to consider the inflationary impact upon the economy of a governmentally financed and administered program. We are all aware of the present difficulties through which our economy has been passing during the past two years. The Federal budget has been near the breaking point with a scope of deficit spending which is staggering in comprehension. Federal spending has arrived at the point at which the public is unable to withstand the two-pronged assault on it of inflation caused by deficit spending and of high taxes imposed in order to support Federal programs.

Within the health care sector of our economy we can identify certain causes for rising costs—better but more expensive technology, care of chronic conditions, expensive liability insurance, and higher labor and supply costs. However, these are only partial reasons. In order to appraise the factors leading to rising costs in health care, this Association is convening a national Commission on the Cost of Medical Care to be composed of individuals representing various sectors of the health care field and of the public.

In the meantime, however, Mr. Chairman, in order not to increase inflationary pressures and deficit spending, nor to hinder medical technology and the forward strides taking place in health care development, we must caution against any Federally controlled and administered national health insurance program. Should we rush into such a system, the result will be a decrease in quality care and in availability.

We would also caution that no national health insurance system can achieve its goals without the support and commitment of providers of services. Artificial and unrealistic limitations on reimbursement or interferences with the practice of medicine will curtail availability of service and defeat the purposes of the program.

CONCLUSION

In conclusion, we submit H.R. 6222 as the health insurance program best suited to fulfilling the national need. We urge your favorable consideration of H.R. 6222 as being based upon those principles on which any national health insurance program must be founded.

Mr. Chairman, we will be pleased to respond to any questions which the Subcommittee may have. We wish again to state our appreciation for the opportunity to appear before you and present our views. Please be assured that it is our desire to be of assistance to the Subcommittee as it considers this and other legislation affecting the health care of our citizens.

ATTACHMENT 1

TABLE I.—CHANGES IN "PRIMARY CARE" RESIDENCY PROGRAMS AND 1ST-YEAR POSITIONS, 1968–74

Specialty	Programs				Total first-year positions			
	Number of approved programs			Percentage of change, 1968–74	Number of 1st-year positions filled			Percentage of change, 1968–74
	1968	1973	1974		1968	1973	1974	
Family practice		206	232			766	1,197	
General practice	154	51	38	−75	254	176	157	−38
Internal medicine	419	433	422		2,589	4,139	4,571	+77
Obstetrics/gynecology	358	347	330	−8	759	1,003	1,047	+38
Pediatrics	260	274	262		1,002	1,699	1,842	+84
Total	1,191	1,311	1,284	+8	4,604	7,783	8,814	+91

Specialty	1st-year positions filled								
	Number of United States and Canadian graduates			Number of foreign medical graduates			Percentage of foreign medical graduates		
	1968	1973	1974	1968	1973	1974	1968	1973	1974
Family practice		720	1,124		46	73		6	6
General practice	116	33	23	143	143	134	56	81	85
Internal medicine	1,801	3,154	3,591	788	985	980	30	23	21
Obstetrics/gynecology	433	675	751	326	328	296	43	32	28
Pediatrics	651	1,141	1,252	406	588	590	41	33	32
Total	3,001	5,723	6,741	1,663	2,090	2,073	36	27	24

	Total U.S. graduates	Percent increase	Percent U.S. graduates in 1st-year positions
1968	7,973		38
1973	10,391	+30	55
1974	11,613	+46	58

ATTACHMENT 2[1]

TABLE 2.—STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS, 1930–75

Year	Number of schools[2]	Total enrollment	1st year	Intermediate years	Graduates
1930–31	76	21,982	6,456	10,791	4,735
1935–36[3]	77	22,564	6,605	10,776	5,183
1940–41[3]	77	21,379	5,837	10,267	5,275
1945–46	77	23,216	6,060	11,330	5,826
1950–51	79	26,186	7,177	12,874	6,135
1955–56	82	28,639	7,686	14,108	6,845
1956–57	85	29,130	8,014	14,320	6,796
1957–58	85	29,473	8,030	14,582	6,861
1958–59	85	29,614	8,128	14,626	6,860
1959–60	85	30,084	8,173	14,830	7,081
1960–61	86	30,288	8,298	14,996	6,994
1961–62	87	31,078	8,483	15,427	7,168
1962–63	87	31,491	8,642	15,585	7,264
1963–64	87	32,001	8,772	15,893	7,336
1964–65	88	32,428	8,856	16,163	7,409
1965–66	88	32,835	8,759	16,502	7,574
1966–67	89	33,423	8,964	16,716	7,743
1967–68	94	34,538	9,479	17,086	7,973
1968–69	99	35,833	9,863	17,911	8,059
1969–70	101	37,669	10,401	18,901	8,367
1970–71	103	40,487	11,348	20,165	8,974
1971–72	108	43,650	12,361	21,738	9,551
1972–73	112	47,546	13,726	23,429	10,391
1973–74	114	50,886	14,185	25,088	11,613
1974–75	114	54,074	14,963	26,397	12,714

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[1] To appear in JAMA in final issue of 1975.

[2] Prior to 1956–57, schools in development were not included.

[3] For the years 1931–32 through 1941–42, 2 schools reported total enrollment and graduates only.

Mr. Rogers. Thank you very much, Dr. Parrott, for a very helpful statement. We are grateful to you for your presence.

Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman.

Doctor, we have heard a great deal of discussion about the problem of rising health care costs, about which I am certainly concerned.

What would you say are the incentives in your bill to curb inflation and the costs of medical care?

Dr. Parrott. Well, I think the main curb on inflation, of course, is not to heat up the system, not to produce more demand on the system than the system can bear and thereby cause the cost overruns that we experienced, such as in medicare.

And the reason I think this bill will affect inflation the least in this respect is that it is using a great deal of the money that is already being spent on health care insurance premiums in the private sector and that the coinsurance requirement in the bill is a brake on overutilization, which is another problem.

Inflation was particularly a problem with medicare at one time, and it was a problem when the Federal employees ambulatory care under Blue Shield here in the District was increased.

So I think those safeguards are built into this legislation.

Mr. Carter. What would be the total cost of your bill?

Dr. Parrott. The total cost has to fall into two categories.

Mr. Chairman, I brought Mr. Peterson along today for the detailed parts of our presentation because he spends full time at this. But as I understand it, there is $45 billion old money already spent, premium money.

The new money we are talking about is a range from a low of $3.6 billion to $4.9 billion, and Mr. Peterson tells me that the difference is in the number of people that are unemployed at any given time.

Mr. Peterson. The figures that Dr. Parrott presented relate to the new net cost to the Federal Government with respect to this program. The $3.6 billion net cost increase to the Federal Government is based upon a projected 5-percent unemployment rate.

The $4.9 billion figure contemplates a 10-percent unemployment rate and the difference results because the program is aimed in large part to the use of Federal subsidies for the unemployed and the poor individuals.

If the unemployment rate increases, then there would be increased cost to the Federal Government, and that is why there is a difference in the two figures.

Mr. Carter. Yes, sir.

Do you think our economy could stand an additional $107 billion in payment for medical care at the present time?

Dr. Parrott. Are you taking new money?

Mr. Carter. Yes, sir.

Dr. Parrott. No, I don't think it could stand that.

Mr. Carter. What do you consider to be the particular strength of H.R. 6222?

Dr. Parrott. Well, it is the most comprehensive plan that has been presented in that it has a very extensive benefit package for its projected cost. It uses the administrative machinery that had already been tried.

In other words, the claim review mechanism of the private insurance company is incorporated as against having to set up a whole new Federal bureau which, needing to be put in effect from the beginning would not have the same experience.

Therefore, we think the cost/benefit, cost/effective ratios would be much better than any other proposals we have heard.

Mr. CARTER. What are the incentives to induce efficiency in the use of medical resources?

Dr. PARROTT. Incentives?

Mr. CARTER. What are the incentives to induce efficiency in the use of medical resources?

Dr. PARROTT. Well, of course, efficiency is a term that really doesn't belong in the medical lexicon. We would prefer to have quality care based on a 1-to-1 basis.

When you talk about efficiency you are talking about the efficiency of a utility company or a cost effectiveness in industry. I do not think, sir, that efficiency is easily defined in a medical environment, unless I misunderstand your use of the word "efficiency." If you are talking about efficiency relating to cost payment, again I will have to say the most efficient systems we have seen have been in the insurance industry.

Mr. CARTER. I could phrase this in a different way to ask you how would you prevent overutilization?

Dr. PARROTT. Overutilization is preventable in a number of ways. One method that I know of, of course, is the "retrospective" utilization review committees which are in effect now under the medicare-medicaid programs.

Review programs are also in effect for all the other people in the country that go to hospitals. These are in hospital committees that tend to prevent overutilization and unnecessarily prolonged hospital stays.

And I think that wouldn't be changed, it would probably be hypertrophy to suggest even greater efficiency.

This type of existing peer review has been put into action as well as other types of retrospective reviews such as medical audit, tissue committees, insurance rate review committees, grievance committees.

Those all have been mechanisms of the medical profession. They are in effect across the country.

Mr. CARTER. Thank you very kindly for an excellent statement and good answers. I believe my 5 minutes are up.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Thank you, and I, too, want to thank you for a very fine statement. I think either AMA has gotten a better writer or you have made a unique contribution. It was very well written.

Dr. PARROTT. I wouldn't pretend I wrote all my own material.

Mr. PREYER. The last witness we had testified about the British Columbia plan. One plan that had been recommended to us had been Canada's.

Do you have any comments about their approach to this problem?

Dr. PARROTT. I am not an expert on the Canadian system, although I was born in Canada and half my first cousins live there. However, the trouble with the Canadian system is that to understand it all, you have to understand it Province by Province because each Province is a little different. I do know only a very little bit about the British Columbia system through an association that I belong to in the Pacific

Northwest which is called the Pacific Northwest Obstetrical & Gynecological Society; half of its membership is Canadian. The aura that everything is sweetness and light in British Columbia has, I think, some qualifying factors if what I hear from my compatriots in British Columbia is true; they are not as totally satisfied as the Congressman would have indicated.

Now, these dissatisfactions, of course, are personal things and I have no way of knowing how profound they are, but they do have a problem, as I understand from these physicians, with excessive paperwork, and also they have a problem with waiting lists in the hospital; but these are not nearly as profound as they are in Britain.

Mr. PREYER. If I could just ask a more general question, What are the major differences between your bill, H.R. 6222, and the administration's bill of last year?

Dr. PARROTT. Of last year?

Mr. PREYER. Yes.

Dr. PARROTT. A part of the bill has been termed by some a compromise with that bill, which was called the CHIP bill. That part of our present bill which was inserted this year was the arrangement between the employer and employee contributions to pay premiums on insurance.

We accepted that and I would suppose you might say that is a form of compromise although it's a rational compromise because we were looking for new sources of revenue.

We did not want to increase the general taxation and, of course, it's against policy from our point of view to increase payroll taxes for national health insurance. A great deal of the new program is already based on the employer and employee system of buying insurance for the working people. Many, many employers already do this; therefore, it least disrupts what you are doing.

Mr. PREYER. Why did you change your approach from the tax credit approach? Was that part of a compromise?

Dr. PARROTT. We still have the tax credit approach, and I am going to ask Mr. Peterson to answer that if he may.

Mr. PREYER. Sure.

Mr. PETERSON. Mr. Preyer, one part of the question has been answered by Dr. Parrott when he indicated that, considering the state of the economy and the pressures that were already existing on the Federal Government with respect to Federal expenditures, the program here would make less demand upon the Federal Government but still provide the necessary care, the necessary insurance, for our people.

It does this by providing the coverage through the employers, and in that sense it retained the feature that was in the CHIP program.

A major element of the cost of the program would be in the section of the bill that requires the employers to provide the insurance to the employees.

Now, the tax credit does exist in the program because it provides a mechanism of providing assistance to those who are not employed and also to those who are self-employed.

Mr. ROGERS. Mr. Scheuer.

Mr. SCHEUER. I am sure we have all been very impressed with your very thoughtful and well articulated testimony.

I would almost like to go through it page by page because there is so much in there that is stimulating and provocative.

You do talk about the constraints of cost and impact of inflation and you state that Americans do put health care somewhat down the line on our list of priorities. That may or may not be true, but you are quite right, there are cost constraints. You don't seem to want to place any restrictions on any portion of the private sector, you don't want to have hospitals limit fees to doctors, you are not in favor of utilization reviews.

What are you in favor of to limit the seemingly irresponsible increase in medical costs that we have seen that don't seem to have been accomplished by increases in health output?

The unnecessary hospital stays, the unnecessary drug prescriptions, unnecessary surgery, physician income from Government-supported programs that range into the hundreds of thousands of dollars a year annually.

We have all read the same newspapers. What do you prescribe as a way we can get a handle on costs? We are already spending 8½ percent of our GNP on medical care and that seems to go up irresistibly every year. We have to get a handle on it. And I don't see anything in your testimony that would help us to do that.

Dr. PARROTT. Mr. Scheuer, there is quite a bit built into the bill that answers many of the questions you asked.

You started off with a general question and then covered four or five specifics.

Let me cover the specifics first.

Actually, we are not against review. We had a suit over what was called concurrent review and won it. And I mentioned in our statement that we are in favor of utilization review, which is retrospective review.

Now, the way you do that, is by correcting it after you find out what has gone wrong, rather than try to interfere with medical care. This interference would be very unfortunate in medicine because when a person is sick the doctor must work on an unfettered basis without regard to restrictive concerns. This has always worked well on a retrospective basis.

We have additional controls built into this bill because of the fact that we are using a usual, customary and reasonable fee, which is a cap in itself on what can be charged. It is subject to review, rate review.

Mr. SCHEUER. Doesn't that usual and customary go up every year?

Dr. PARROTT. Although the cost, the price index has gone up, fees have not gone up unusually until just recently because of the malpractice problem. But, the increases have been pretty close to what the increase in living cost has been in the past. Not so particularly with the hospitals but then they have another problem, a labor problem, which won't stop for them.

Physicians represent about 13 percent of the medical care dollar and about 20 percent of the health care bill, so that we are not fully in control of the whole cost of health care, although I understand that it's doctors that put people in the hospital and it's the doctors that say when they can go home, but we try to—the controls of utilization review are built into the situation, the controls through a type of peer review are built in, and if and when national peer review becomes effective that will have application on this situation also.

Now, the general question that we have done nothing to keep costs down just isn't so.

Mr. SCHEUER. I didn't say that. Don't put words in my mouth, Doctor. I am asking you what would be included in your program to give us a handle on costs.

Dr. PARROTT. What I have said, the control through this and also through the review mechanisms and also through certain kinds of arbitration as far as rates are concerned.

We don't adhere to a fee schedule and control has to be built around the word reasonable; we do have mechanisms for holding that down at the local level.

Mr. SCHEUER. On page 16 you talk a good deal about human behavior, and you say that national health insurance can't necessarily meet the probems of human behavior, and you talk about smoking, diet, exercise, clean air, drug addition, alcoholism, proclivity to get involved in accidents and violent behavior.

This committee is dealing with the business of clean air and healthful environment. You are absolutely right that life-style, quality of life and of health cannot be immediately rated specifically by any one system of delivering health services, but I think you have done us a great service in identifying smoking, diet, exercise, drug addiction, alcoholism, as among the major determinants of health outcome.

From your perspective, what do you think this Congress should do about helping people organize their lives better so that they use the system better, they use the preventive care elements in the system better and they organize their lives better in reference to all of the things that you outline?

What do you recommend that we do in terms of legislation to help people?

Dr. PARROTT. Well, of course, I feel that there is little we can do without the help of the public in that area. Public education has been one of the major features of American Medical Association publications.

Two-thirds of our overhead is publishing. I think we have assisted the Government in many ways in helping the profession and serving the public through publications, like drug evaluations and means of describing what we do.

I think that it will take a combined effort of medical organization and Government zeroed at the public. There is no way an individual doctor can impact like these organizations can. That is why the organizations, especially local societies and national associations, are very necessary.

Mr. SCHEUER. Can't the prepaid——

Mr. ROGERS. I am sorry, the gentleman's time is up.

Mr. Maguire.

Mr. MAGUIRE. Thank you.

I yield to the gentleman if he was in the middle of a sentence.

Mr. SCHEUER. The prepaid HMO in your town I understand is doing an excellent job. Isn't one of their perceived missions to help people in terms of preventive health, look at their own behavior? Isn't that a role especially that the HMO's and other prepaid organizations can fill and are really quite willing, well designed to fill?

Dr. PARROTT. Well, I answer that in this way, sir.

I have had no experience with available HMO because they are few and far between at the present time. The Kaiser Permanente organization is a successful organization. It took 25 years to evolve. It does no better job in preventive medicine than does the private sector outside that group. It doesn't do any worse job.

I think they do about an equal job.

Now, I think it takes general education, and closed panel groups can do it as well as open panel groups or straight groups or mixed groups or however you want to group them, but I think it takes a nationwide impact.

We have had impact on smoking. I think from the start of the surgeon general's report we have made a big impact on smoking.

I think we have to do this with education.

I would hate to go back to the Volstead Act to try to force that sort of conduct, but I think we are making progress and we should continue to plug the public education on what is good lifestyle.

Mr. MAGUIRE. On the Kaiser matter, Doctor, isn't it true that the rates of hospitalization are running something like 50 percent below the coverage nationally in the Kaiser system?

Dr. PARROTT. You are talking about utilization?

Mr. MAGUIRE. Right.

Dr. PARROTT. Well, I won't accept the 50-percent figure. They do underutilize, therefore, they are less on utilization than the fee for service.

Mr. MAGUIRE. They do underutilize?

Dr. PARROTT. Yes.

Mr. MAGUIRE. Isn't there something to be said for the security that a family might feel they have had by having a prepayment and knowing they were going to have any care that they need through the year for that price and any time in the day or night be able to get the appropriate doctors, as is true under the Kaiser plan?

Dr. PARROTT. It probably satisfies some families very well, sir. It satisfies other families not at all. I live in a Kaiser town and I know insideout what the families do. I see about as many Kaiser patients as does the Kaiser plan see of mine, so it's a kind of draw.

Mr. MAGUIRE. Could you tell us how your legislation would foster innovation and/or reorganization of the health care system, for example, new types of personnel or the system for delivering and paying for care.

Dr. PARROTT. Well, we have done this already, of course. We have encouraged the grouping of physicians. They have done it a great deal on a voluntary basis around the big, larger community hospitals.

You will see that the larger groups have gathered in the hospital campus on an informal referral basis and have formed that kind of center. It isn't as rigid as an HMO or as a health care corporation.

We think it's more flexible, and we think the referral basis is much better. Having a rigidity around a group doesn't offer any great advantage economically.

Mr. MAGUIRE. Let me turn for a moment to the coinsurance aspect. As I understand it, 20 percent coinsurance applies across-the-board, the difference being in who pays ultimately.

Now, for the poor, who will be reimbursed by the Government under your plan, am I right so far?

Dr. PARROTT. Well, the Government purchases the insurance which covers them and there is no coinsurance on the poor.

Mr. MAGUIRE. So the poor do not have out-of-pocket payment at the outset?

Dr. PARROTT. That is right, sir.

Mr. MAGUIRE. With regard to quality and assurance, the program as you have spelled it out appears to be advisory in nature on the question of quality and planning.

Are there any sanctions the Health Insurance Advisory Board could undertake when the providers don't follow their advice?

Dr. PARROTT. Well, there are no sanctions per se in the bill. There are peer review mechanisms in the hospital which will discipline a physician at that level. If the discipline comes to the office practitioner, it would come through the State Board of Medical Examiners under the present arrangement. But I think that the utilization review committees do a pretty good job in most of the big community hospitals of holding down overutilization.

Mr. MAGUIRE. What about the planning process, is there anything that we could identify in the legislation you propose that——

Dr. PARROTT. I think this whole legislation involves planning.

Mr. MAGUIRE. Is there anything, for example, that relates to physician and maldistribution by location or specialty?

Dr. PARROTT. Not specifically if you are talking about a forced type of redistribution.

Mr. MAGUIRE. What about budgetary planning?

Dr. PARROTT. Well——

Mr. MAGUIRE. One of the strengths of the Young or Corman bills, in my judgment, is that there is a budget planning procedure which results in clear definitions of what is and is not acceptable, and then the reimbursement doesn't exceed that.

Mr. ROGERS. The gentleman can go ahead and finish.

Mr. MAGUIRE. May I finish the question?

Mr. ROGRERS. Certainly.

Mr. MAGUIRE. The question would be is there anything in your bill which we could describe as planning with teeth in it, and, second, how do you deal with the problem of reimbursement formulas which permit for passthrough of costs?

Dr. PARROTT. That is the beauty of our bill, it's flexible, it has pliability and it can apply to the patients as individuals and not force a cookbook type of medicine on the American public.

Mr. MAGUIRE. Which means each one continues to be ripped off?

Mr. PETERSON. May I make one comment on that?

While it has been characterized by the Congressman as a strength, the budgeting process in the Corman bill is viewed by many as one of the weaknesses of the bill in that it can operate as a restraint on delivery of medical care.

Mr. MAGUIRE. What was that?

Mr. PETERSON. It can operate as restraint on delivery of medical care. There are differences of view with respect to any benefits, so-called benefits, that derive from the budgetary process under the Corman bill.

Mr. MAGUIRE. I can't resist the joinder to your comment. I thought we were trying to provide care, to improve provision of care rather than to restrain delivery of care at a time when we clearly have a tremendous deficit.

Mr. PETERSON. I think the budgetary process may operate as a restraint on delivery.

Mr. ROGERS. When would your bill go into effect, say, if it were to be enacted in 1976?

Dr. PARROTT. We would need, I think, a year's leadtime.

Mr. PETERSON. It would go into effect in 1978.

Mr. ROGERS. If it were passed in 1976?

Dr. PARROTT. Yes, sir.

Mr. ROGERS. So about a 2-year period?

Mr. PETERSON. That is correct. The second calendar year after enactment.

Mr. ROGERS. Total cost again?

Mr. PETERSON. Well, the costs that I have indicated here have been the cost to the Federal Government. This takes into account the cost that would be involved in the tax credits and the subsidies to the employers; and as offset against any increased costs there would be offsets of saving through the reduction in medicaid expenditures. There would also be an increase in revenue to the Federal Government by virtue of a reduction in the use of medical deductions under the income tax system.

Taking the offsets from the gross cost, there would then be a net cost to the Federal Government of $3.6 billion based on 5-percent unemployment rate or $4.9 billion based on a 10-percent unemployment rate.

Mr. ROGERS. I see. What is the amount it would cost the Government for the tax deductions as such that you would allow, what is that figure?

Mr. PETERSON. The tax credits?

Mr. ROGERS. Yes.

Mr. PETERSON. I would have to vertify that. I believe that figure would be aprroximately—here again it would vary based upon the unemployment factor.

Let's use the 5-percent figure.

It would involve as far as the subsidies to the persons under 65, $5.3 billion. And to the over 65, because of the supplements that may be made to the medicare beneficiaries, $0.7 billion. Then with the subsidies to the employers this would bring the cost to approximately $9 billion. Then when you reduce the savings factors that then brings it to the $3.6 billion.

Mr. ROGERS. Those saving factors were mainly——

Mr. PETERSON. Reduction in medicaid expenditures because the program would in effect take over most of the medicaid program, and also the savings would be in net increase in tax revenues because individuals who take the tax credits would then not be eligible to take the medical deductions on their income tax return.

So those are the two elements as a savings then.

Mr. ROGERS. Do you allow any medical deductions?

Mr. PETERSON. Medical deductions would be retained. They are not abolished. For instance, some individuals may very well have a better credit with the Government on their income tax return using the medical deductions rather than the tax credit, but it would be on an individual basis.

Mr. Rogers. What do you estimate that might be? What would that amount to, would you think?

Mr. Peterson. I am not sure just exactly. The only figure that I can propose at this time is with respect to those individuals who would not use the medical deductions that have been using them in the past; this figure would be $1.3 billion as an estimate.

Mr. Rogers. All right.

Now, you do provide for Federal funds to an employer where there has been an increased payroll cost?

Mr. Peterson. That is correct. If the increase is greater than 3 percent then there is a subsidy to that employer and this subsidy is one that would extend over a 5-year period.

Mr. Rogers Starting at 80 percent?

Mr. Peterson. Yes; and then reducing at the rate of 10 percent each year.

It also provides for a study to be made with respect to whether there should be any continuation of the subsidy or whether it should be changed in form and amounts and so forth.

Mr. Rogers. So the highest tax that an employer would be what, for insurance?

Mr. Peterson. Well, if you are talking about the total insurance cost to the employer, of course that would depend upon the number of employees and those factors.

Mr. Rogers. I was thinking of an average policy?

Mr. Peterson. Average would be, we figure as far as the cost of the policy, just in excess of $900, $913. That would be for a family of four. On an individual basis, again averaging cost, would be about $280.

Mr. Rogers. About $280. I see.

Now, as I understand it, you cover the poor and the near poor up to what level?

Mr. Peterson. Well, there is no limitation with respect to the coverage. There is full subsidy.

Mr. Rogers. Is there an income determination as to those categories?

Mr. Peterson. Yes, as far as the poor are concerned, it's based upon their tax liability. We feel that most equitably takes into account the question of the Federal support, the various elements that go into the question of determining the tax liability after you first determine their gross incomes.

By the time you determine their tax liability there have been several equalizing factors that go into the tax determination.

So based on the tax liability, as to those individuals or families that have no tax liability, they would be supported in full by the Federal Government.

Now as tax liability increases the Federal support decreases; and it's a very gradual scale, and it's based upon the table that is in the bill. Eventually there is 10 percent support for all individuals.

Mr. Rogers. How much all together?

Mr. Peterson. Ten percent for all individuals even though they would have a higher income.

Mr. Rogers. Yes. I see.

Now, that would be determined on the last year's tax basis.

Mr. Peterson. That is right, Mr. Chairman.

Mr. Rogers. And suppose they had more than that income in the coming year, what would you do, how would it be administered?

Mr. Peterson. That income then would be reflected in the following year in the determination of their eligibility under the program. You have to use the previous year in order to ascertain a definite amount of income.

Mr. Rogers. In other words, he would be supplied with whatever his tax return showed for the prior year, that would control what he would have to pay or what benefits he would receive for the coming year?

Now if his income changed during that period, you would adjust it at the end of the year in which he filed his tax return?

Mr. Peterson. Well there would be no adjustment in the benefits that he would receive for that year.

Mr. Rogers. Suppose he had to pay taxes for that year?

Mr. Peterson. For the second year?

Mr. Rogers. Sure.

Mr. Peterson. That would be reflected in his eligibility the following year.

Mr. Rogers. Well, actually in the year he gets his benefits then he may be making $100,000, but because the year before was kind of a bad year for him, he gets all his coverage free.

Mr. Peterson. If his income was low during the previous year that would determine his eligibility for the benefits during the coming year.

Mr. Rogers. No adjustments.

Mr. Peterson. There would be no adjustments on that basis.

Mr. Rogers. Then the third year? The third year he would be controlled by the $100,000.

Do you think there should be any adjustment during that period of time when he is making a lot of money?

Mr. Peterson. If some system could be worked out equitably; the difficulty in having the income of the current period match the benefits for that period relates to the eligibility.

Mr. Rogers. I understand. What I am saying, should there be adjustment at the end of the year or is the paperwork too much to offset the gains in equity?

Mr. Peterson. I think we would like to consider that factor again.

Mr. Rogers. Would you let us know on that?

Mr. Peterson. Yes, I would think that could be reconsidered.

Mr. Carter. On that very line, the House recently voted not to carry back taxes for the preceding 3 years as a tax credit. I really think that everyone wants to get out of poverty when poverty stricken. The only way we can judge it is by his income for that year. When he gets to making money, which we hope all people do, he can pay for his premiums.

Mr. Rogers. For instance, everybody who got out of college would probably have their first year of health care subsidized, would they not?

Dr. **Parrott.** Yes, perhaps, unless they became covered through employment.

Mr. **Rogers.** It's a good start. It may be good.

Mr. **Carter.** He might well need it.

Mr. **Rogers.** The committee will stand in recess for 10 minutes.

Mr. **Scheuer.** May I continue?

Mr. **Rogers.** Certainly.

Mr. **Scheuer.** Under your program, what would become of medicaid, the present medicaid program, and who would be served, what benefits would be provided, and particularly what would the provisions be for long-term care?

Dr. **Parrott.** Under this program medicaid would be absorbed in a premium purchase by the Federal Government. There may be some State participation although it would do away with the matching programs now as far as medicaid was concerned?

There are some problems when the State comes into it?

Mr. **Peterson.** May I add to that.

Mr. **Scheuer.** Sure.

Mr. **Peterson.** The bill itself does not eliminate the medicaid program in a formal way. By virtue of the fact that most of the medicaid people would be provided care under our program, with respect to their basic and catastrophic comprehensive benefits, most of the medicaid program in this sense would be absorbed into this program.

Mr. **Scheuer.** Which——

Mr. **Peterson.** They would not necessarily be removed entirely, as far as your question with respect to the provision of extended care in skilled nursing facilities beyond 100 days. The 100-day limitation, of course, is just a matter of fiscal limitations. If the program can absorb increased costs that figure can be extended. It can also be covered through an extension of the medicaid program to pick up any additional benefits that are not covered under this program.

Mr. **Scheuer.** Why——

Mr. **Peterson.** Just as we find in other programs, other national health insurance proposals, there is a limitation on the skilled nursing facility care offered.

Dr. **Parrott.** They would have to fall back on the States after the 100 days.

Mr. **Scheuer.** On State programs?

Mr. **Peterson.** It could be State or continuation with the Federal Government if there was a determination made to continue medicaid for that purpose.

Mr. **Scheuer.** Which portion? Present medicaid constituency that is covered would not be covered under your program? You say most of them would be covered.

Mr. **Paterson.** I would say all of them would be covered.

Dr. **Parrott.** That is what I was going to say.

Mr. **Scheuer.** The entire——

Mr. **Peterson.** Yes.

Dr. **Parrott.** It's a straight across-the-board purchase. Where the State comes in is really when you run out of the program on 100 days with respect to skilled nursing care. Further, in an acute case you are covered fully, under our bill, particularly on the catastrophic, but where you run into longer problems as chronic cases, they run closer to custodial care, and no bill has covered custodial care. So it has to revert to the State at that level.

Mr. SCHEUER. Any role in your program for the consumer?

Dr. PARROTT. Yes, there is in this bill. There is a National Health Insurance Advisory Board, composed of 15 people which really is the administrative body that sets the guidelines and the operating climate of the bill.

On that I think there are a certain number of providers, five physicians, but there are actually more so-called consumers than there are physicians on that body. You might give him the totals.

Mr. PETERSON. The Board is a 15-member Board which is appointed by the President and consists of the Secretary of HEW and the Secretary of the Treasury as members. In addition there would be seven physicians and a dentist and the others would be appointed from the general public at large.

In addition to that, the Board of course, could call on members of the public to act in an advisory capacity. But then the consumers would be represented through the members of the public who would be on this Board.

Mr. SCHEUER. On the National Board?

Mr. PETERSON. That is correct.

Mr. SCHEUER. At the local or State level?

Mr. PETERSON. For the State level there are provisions for use of the State in certain administrative matters. The States then would work in conjunction with professional associations in the State and would consult with carriers and also members of the public. Particularly I would make mention that the Advisory Board, the National Advisory Board is reviewing the effectiveness and the operation of the program would also consult with carriers and professional associations and consumers and members of the public in general.

Mr. SCHEUER. What power would these National Advisory Boards have?

Mr. PETERSON. The National Advisory Board is the Board which would set the guidelines and establish the regulations and the general administrative policies at the Federal level.

Mr. SCHEUER. Would they be appointed by the President?

Mr. PETERSON. Yes; that is correct, with the advice and consent of the Senate.

Mr. SCHEUER. I didn't note in your bill any reference to paraprofessionals in the health service, either in the delivery of health services or as health counselors, particularly for the poor, where paraprofessionals have done a good job even in the areas of mental health.

Do you feel that there is any role for the physician assistant and physician extender, the nurse extender, any of the hundreds of paraprofessional roles that have been developed since World War II, more or less based on the experience of the medical corpsmen?

Dr. PARROTT. Of course you know the greatest numbers of physicians extenders are office RN's, the new extenders, physician assistants, are quite limited in numbers and they have——

Mr. SCHEUER. That is because they have only been recently licensed.

Dr. PARROTT. They are certified. They have been used in a number of general practice settings. These have been utilized as they come out almost as fast as they come out.

I am not real certain that we have to nail down the way they are used in national legislation.

As far as clinical psychologists are concerned, they actually practice independently.

In most cases we would prefer that these folks be under some kind of advisory position with the medical profession, as is the case with the PA, and as is the case with most out-of-institution RN's

An institution RN works under the aegis, at least of the approval. of the medical staff, although they are hired by the administrator. They work in an extended situation, as nurse coordinator, ICU, coronary care nurses, emergency room nurses, or obstetrical nurses. But I don't think that this type of arrangement needs to be laid out in Federal legislation.

Mr. PETERSON. I think, as has been indicated, in the institutional setting or prepaid group practice or HMO, or whatever, or with individual physicians using the paraprofessional, the physician's assistant or the nurse assistant, and where they all operate under the direction and supervision of the physicians, those services as directed and requested by the physicians would be recognized under the program.

Mr. SCHEUER. It's 4:30 and I must go for the vote so we will recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. May I say on behalf of the committee that we apologize to you for this constant interruption this afternoon but we have had votes in the full committee where we had to be present.

Let me just ask this.

I think we had gotten into how the poor are covered and so forth. And everyone who is employed would be covered or has the right to be covered. Is it mandated now; would you mandate coverage?

Dr. PARROTT. Mandate on the employer, not on the employee.

Mr. ROGERS. Now must there be a choice for the employee?

Dr. PARROTT. Yes.

Mr. ROGERS. I assume that the law would prevail, it would be an HMO or some other plan.

Mr. PETERSON. The employer would offer the plan to the employee, yes.

Mr. ROGERS. So there would be a choice for the employee.

Mr. PETERSON. Yes.

Mr. ROGERS. Now, those over 65 would still be covered by medicare, in effect?

Mr. PETERSON. That is right.

Mr. ROGERS. Do you increase benefits?

Mr. PETERSON. Yes, we provide for a supplemental benefit package to supplement the medicare program so it would be equal in benefits to the other part of our program.

Mr. ROGERS. Is there any subsidizing of that?

Mr. PETERSON. Yes. those elderly who would be of low income would be eligible for the same subsidies available to the rest of the population.

Mr. ROGERS. And then for the supplement, even though they may have medicare.

Mr. PETERSON. Yes.

Mr. ROGERS. Now, suppose they are not on medicare; if they are self-employed they must come under the plan? So everyone should be covered one way or the other, either the poor in the coverage where their income is not sufficient, or if self-employed——

Mr. PETERSON. Yes, the only noncoverage would be those in the military service.

Mr. ROGERS. Yes. And what do you do about the veterans, do you still allow them to be——

Dr. PARROTT. If one is a veteran, he has a choice which way he wants to go. He could go with the veterans or he could stay with the program, but one wouldn't pay the other.

Mr. ROGERS. All right.

I think we touched on some costs. We may want to get into that in detail a little later with you. We won't go into that this afternoon.

What role do you see for PSRO's? What role should they play under the national health insurance program?

Dr. PARROTT. You understand PSRO was written basically for medicare and medicaid.

Mr. ROGERS. Yes; you continue medicare.

Dr. PARROTT. Peer review without national standards is practiced in many hospitals.

As far as this program is determined I would judge that it could serve a purpose if it became sophisticated enough.

Mr. ROGERS. So it would be used as a technique?

Dr. PARROTT. Yes; the state of the art, sir, is not as good as it could be relative to quality assurance. This is the point we have discussed with you at other times. We need more leadtime on it because we have to develop a language, we have to develop a mechanism, but if it became proper and with the reforms—and we have some 19 amendments I would like to push a little bit, too—if we can get into a situation where it's got a good cost benefit, cost effective ratio, then there is no reason why it couldn't be considered for this type of operation.

Mr. PETERSON. The National Board has a function to make recommendations with respect to the review, so, considering the leadtime, this would enable a better determination as to the effectiveness of PSRO's which you know are not in operation at this time.

Mr. ROGERS. There are some in operation.

Mr. PETERSON. That is right, but to mandate them into a program specifically at this time may be premature. So that with the leadtime that would be provided under the program there could be further determination as to their effectiveness so that the National Board could make recommendations with respect to the review mechanism.

Mr. ROGERS. You do support a quality assurance program?

Mr. PETERSON. That is right.

Mr. ROGERS. Would it be PSRO? What else do you suggest?

Dr. PARROTT. There are two elements in this. There is the cost control, which is already built into the professional rate review committees. Insurance companies can turn to this, and have turned to this in many areas. Perhaps rate review committees have so much been used in the small rural areas, but even there rates are usually reviewed by the State associations.

They have access to that. Also other mechanisms could be set up. After all that is where the foundation movements have been initiated. That is where the charges fall off the profile.

Insurance companies have profiles on the physicians, as do the Shields. The Blues have these profiles also.

We would rather see that type of review, if you take the cost end of it, continued because insurance companies have the expertise at the present time. As far as quality assurance is concerned there has been quite a lot of institution utilization review in addition to PSRO.

There has been the quality assurance program of the American Hospital Association; there has been the TAP program of the Joint Commission; there have also been other programs built into institutions.

Those haven't as yet spilled out into the offices. I don't think anybody has a handle on that just yet. But certainly the grievance committees of the major county and State medical societies have had a handle in disciplinary problems relative to physicians in practice outside of the institution.

Mr. Rogers. So, you would leave it in the hands of the medical society?

Dr. Parrott. As far as possible, because I think that with the increase in the malpractice problem, along with the various State boards of medical examiners, I think they will become more efficient at weeding out only incompetency or bad behavior. License authority is with the State board of medical examiners. However, boards do take the advice of State associations and county associations, so I think that could be increased in the way it acts.

Mr. Rogers. Well, I am not clear now what role you would have PSRO's play.

Dr. Parrott. PSRO might have a role, I think eventually, but they have——

Mr. Rogers. This would be a mechanism you would use.

Dr. Parrott. PSRO might have a vote, but only if it became sophisticated enough to do what it should do.

Mr. Rogers. I presume that is so with any plan, isn't it, or any program; we use it if it becomes sophisticated enough.

Mr. Peterson. The thrust of my comment was that since the national helath insurance program will have a delayed effectiveness there will be a period to test the effectiveness of the PSRO's which, of course, at this time is limited to the institution, review of institutional services. During that period there will be an opportunity to survey its effectiveness, and if it's proven to be effective and acceptable, then it can be considered.

Mr. Rogers. What I am saying is this: In your bill do you have any mechanism to provide for quality assurance?

Mr. Peterson. Dr. Parrott has related many of the ongoing activities.

Mr. Rogers. Is it in the bill?

Mr. Peterson. At the present time the provisions in the bill with respect to review relate to the authority of the National Board to——

Mr. Rogers. So you simply say the National Council would be authorized to set it up?

Mr. Peterson. They would review the effectiveness of the program. Its operation provides for planning and revising and developing appropriate mechanisms of review, and it may be at that time that would see that the PSRO would have a role.

Mr. Carter. Does this bill in any way do away with PSRO?

Mr. Peterson. Not at all.

Mr. CARTER. It does not.

Another question on that line.

Did I understand that PSRO might go ot a doctor's office?

Dr. PARROTT. Can I enlarge on that a little bit?

Mr. CARTER. Yes, sir.

Dr. PARROTT. I don't think that the PSRO would be capable really of doing a good job in a doctor's office.

Mr. CARTER. Would any bill regulating a physician's office practice be advantageous?

Dr. PARROTT. It's hard for me to believe it. I think this, if I may state it. A physician is educated in a special way. If he graduates from medical school and is licensed by a State, he has demonstrated integrity and competence; if you are going to go into an office where every picayune procedure in the office is going to be reviewed, you will run into a type of work that will have no end and a cost that would be horrendous; and, therefore, that is the equivalency of saying that it will not go in an office setting.

I rather doubt that it will ever be anything but a straight profile spot check type of situation.

Mr. CARTER. If you would yield further. About how many clerks and secretaries are required now for one physician to fill out the forms which he has to fill out for medicare, medicaid, and similar programs?

Dr. PARROTT. I have an office of five physicians and we run two girls on the forms.

Mr. CARTER. You are very fortunate. You must have a very low caseload because one physician I know with perhaps more than an average practice has two who are entirely assigned to filling out these forms.

Dr. PARROTT. He probably is dealing mainly with people over 65 or with the medicaid group. Our particular practice runs the whole thing.

Mr. CARTER. Yes, sir.

You mentioned malpractice. There's a rather unusual thing we find about malpractice—it isn't the ordinary general practitioner who is sued. Actually in the surgical field, for instance, which group of surgeons are most likely to be sued?

Dr. PARROTT. High category surgeons, the neurosurgeons, the orthopedics, the OB–GYN. The danger in OB is the long tail, which is the 18 years plus the statute. And particularly neurosurgery. Those four or five specialties.

Mr. CARTER. The most highly trained physicians are those who undergo the greatest liability; is that correct?

Dr. PARROTT. Because they are in the high-risk specialties.

Mr. ROGERS. I presume you would use the planning process set up in the latest planning law, in your program; do you envisage that?

Dr. PARROTT. Can I speak to that?

Mr. ROGERS. Yes.

Dr. PARROTT. I haven't gotten a handle on that yet, sir. We have it implemented in our State, but at the present time it's a shambles. I couldn't answer that question, and I don't know of many places that have got it far enough along the line so they could answer it.

I am afraid that we haven't got that written in the law. I don't know how we could use it until it's more operative.

Mr. Rogers. It's already in the law. Do you change it in your bill?

Dr. Parrott. In this bill.

Mr. Rogers. So you would envisage it would also be used?

Mr. Peterson. That is correct, Mr. Chairman. Our bill does not disturb the planning law so that the law that would be in effect would be operative with respect to planning for facilities and distribution of facilities and so forth.

Dr. Parrott. It isn't covered in this bill though.

Mr. Rogers. It's not mentioned?

Dr. Parrott. No.

Mr. Rogers. But there is nothing other than that?

Dr. Parrott. There is no reason why it can't be associated.

Mr. Peterson. There is no reason to duplicate.

Mr. Rogers. Right.

Now, what do you think of the HCC's?

Dr. Parrott. Health care corporation. That is a franchising arrangement, and we oppose that concept.

Mr. Rogers. You don't think that is good. I do know that you would allow hospitals and institutions to be looked at and regulated by State institutions, is that correct?

Mr. Peterson. We provide, Mr. Chairman, for a mechanism of involvement of the State agencies working with, and in consultation with, the carriers and with the institutional providers of the State to provide an acceptable means which may include a variety of forms, prebudget approval and so forth.

Mr. Rogers. You would anticipate some State authority in that?

Mr. Peterson. Yes, some State involvement, yes, sir.

Mr. Rogers. And you do provide for utilization during the period of peer review even though you don't spell it out.

Mr. Peterson. Very definitely.

Mr. Rogers. What about long-term care?

Dr. Parrott. There is a provision, of course, for 100 days of extended care. I think I mentioned, of course, that it is difficult distinguishing between long-term care and custodial care in certain cases, but no bill attempts to make that differentiation. You have 365 days of acute hospital care if you need it.

Mr. Rogers. But custodial care, do you make any arrangement for——

Dr. Parrott. No.

Mr. Peterson. One hundred days is a rather arbitrary determination that was made in order to determine the fiscal costs of the program. Such care becomes an expensive part of the program. But if it's determined that the program should be beefed up in that area, an extension of such coverage would certainly be acceptable.

Dr. Parrott. If a person has a covered catastrophic illness which includes elements of custodial care he is still covered under the bill.

Mr. Rogers. 365 days. So he would have catastrophic coverage.

Dr. Parrott. Yes, sir, he has catastrophic coverage for as long as he needs it based on——

Mr. Carter. $2,000?

Dr. Parrott. Yes. After $2,000 expenditure.

Mr. Rogers. That is copayment?

Dr. PARROTT. Yes, sir, which would mean it would be more than that but the insurance picks up the other 80 percent. Then the insured breaks into catastrophic.

Mr. ROGERS. Is that for 1 year? Must he pay $2,000 per year to trigger that?

Mr. PETERSON. The coinsurance is an annual feature of the bill. I want to clarify——

Mr. ROGERS. A person would have to pay $2,000 every year?

Mr. PETERSON. I want to clarify that because the coinsurance is related to the income of the individual. It is 20 percent of the services but it's related to the income. So that a person who has a low income would not have to spend—we are talking about the $2,000 which would be for a family of four—would not have to expend $2,000 if the income was lower.

The formual in here is coinsurance related to income and it's 10 percent of the income which exceeds a base amount which is related to the poor. This is intended to provide——

Mr. ROGERS. That would also apply in the catastrophic?

Mr. PETERSON. Yes, sir.

Mr. MAGUIRE. Could I ask at what salary or earnings level the full $2,000 kicks in?

Mr. PETERSON. The $2,000 would kick in for a family of four at about $24,000 and for an individual it would kick in at, I think, about $19,000.

Mr. MAGUIRE. Thank you.

Mr. PETERSON. I am sorry; it's $16,500.

Dr. PARROTT. For an individual?

Mr. PETERSON. Single individual.

Mr. ROGERS. Suppose you do have catastrophic costs; you pay that amount as you say so you have coverage.

Now, you would get coverage in the hospital but you wouldn't get it in the skilled nursing home?

Mr. PETERSON. For 100 days in the skilled nursing home.

Mr. ROGERS. But not 365?

Mr. PETERSON. That is right.

Mr. ROGERS. Wouldn't it be cheaper to provide, if it's appropriate, that such a person could be taken care of in the skilled nursing home rather than 365 days in the hospital?

Mr. PETERSON. Mr. Chairman, I am sure there would be no objection to an extension of that 100 days. It's a matter of dollars and a matter of being able——

Mr. ROGERS. It would be cheaper in the skilled nursing home, if it's an appropriate place to treat them, wouldn't you agree?

Dr. PARROTT. Yes; there would be no objection to that kind of variation. I can envisage the kind of case you are thinking about. I think it would be a quadriplegic or hemoplegic that can't get back. Eventually those folks become custodial.

Mr. ROGERS. What do we do for them?

Dr. PARROTT. Well, I think quadriplegic you then have the differentiation to make and you have to make it by some kind of medical decision which says the person is not custodial. It's necessary that they require a certain kind of care to say, let's say, or something of this nature, but that has to be determined almost on a case by case basis.

Mr. ROGERS. I notice that you do provide for home care.

Dr. PARROTT. Yes, sir.

Mr. PETERSON. Yes.

Mr. ROGERS. What does that provide?

Mr. PETERSON. All home health services to an individual under a psysician's care.

Dr. PARROTT. Well, in this context it means the usual health home services which in many cases are visiting nurses who check on the convalescent or post operative patient to make sure that they are properly taking care of themselves.

Mr. ROGERS. They are entitled to 365 days?

Mr. PETERSON. That would also include such things as physicial, occupational, or speech therapy, medical supplies and use of medical appliances that would be formulated under such a plan.

Mr. ROGERS. What about drugs? What coverage do you have as part of hospital inpatient? What about outpatient?

Mr. PETERSON. There is no coverage for outpatient drugs in the program. There would be full coverage of drugs in the institutional setting whether it's hospital or skilled nursing facility.

Mr. ROGERS. Should we allow some outpatient so a family doesn't put pressure on the doctor to put him in the hospital so he can get his medicines paid for? If it is cheaper?

Dr. PARROTT. Well, I think that could be adjusted, too. I would like to point out this is one of the problems where they really have trouble with the National Health Service in Britain. They finally had to put a front-end load on the prescription because it was getting out of hand.

So there has to be some kind of top, some kind of a safeguard built in, but I think that could be——

Mr. ROGERS. I think if you could let us have your thinking along those lines it would be helpful too.

[The information requested was not available to the committee at the time of printing.]

Mr. ROGERS. Mr. Maguire.

Mr. MAGUIRE. Thank you.

Doctor, one of the characteristics of the fee structure is, as it presently exists—I think you would agree with this—is that the fee system reward procedures more than it rewards serving people with preventive medicine or primary care. A doctor might be paid between $10 and $50 for treating somebody on an outpatient basis, whereas the fee for a procedure, a gall bladder operation for example, might be much higher, $500 even though the time spent by the physician might be the same.

Are there provisions in your bill which would offer financial incentives for physicians who provide preventive care or primary care?

Dr. PARROTT. Well, that would rather hinge around how you are going to define preventive care. Preventive care, if you are talking about medical care, hinges in this day and age basically around immunizations, periodic physical examinations, which include pap smear, breast examinations, and periodic blood pressures and screening situations, and as far as laboratory work is concerned, the blood work.

Now most of that is moderately expensive as far as doctors go. Internists services may generally be more expensive since their procedural situations are fairly substantial.

However, a full blown physical examination and adequate history in most internists offices, will run in the neighborhood, at least in my part of the country, of $75 to $100.

It's true that the surgeon is rewarded more for a procedure. He is also in a higher risk end of things. But this is also changing gradually for the internist, particularly the cardiologist who is becoming more sophisticated in the diagnostic studies he does as it relates to cardiac catherization and as he builds up towards more sophisticated heart care.

So also he is experiencing a higher risk with those procedures costing more money. EEC is costing more all the time. The cost of technicians is more, and the machinery is getting more complicated.

So I would agree there has been a differential here, Congressman, but we haven't built a fee schedule or any kind of a substance like this into the bill.

We have suggested usual customary and reasonable as a guide, but then that is a flexible guide.

Mr. MAGUIRE. Flexible in the sense that the doctor can charge more if he wishes.

Dr. PARROTT. He can charge more if he wishes. If he falls off the profile there are disciplinary situations which will correct it. The rate review committees won't accept out of line charges, and, I think, if you look at any computerized profile on physicians, you will find they fit the Bell Curve like everybody else.

You have the low chargers and you have the high chargers. If you put the line in the middle of the Bell Curve half of the people are below the line, the other half are above the line, and you have the extreme ones at either end, those that give service away and those who charge too much. We never discipline the physician that is low. We do discipline the physician that is high because of the cost factor. I have a feeling——

Mr. SCHEUER. How do you discipline those who are too high?

We had a case in New York of a doctor who took almost $900,000 out of the system in 3 years and didn't do anything wrong, he just made a hell of a lot of money.

Dr. PARROTT. Are you talking about medicaid?

Mr. SCHEUER. Yes.

Dr. PARROTT. You are talking about a volume business in a depressed area and probably if he was taking that much out legitimately it was because the group he worked with were working long hours and running very short visits.

Now the argument on behalf of that physician may be that if he were not there to see the patient, even in this way, there would be nobody there to see him. So that some of those cases have been shown to be legitimate within that framework.

What we really need are more people down there to give so they get better volume spread, but that is the only answer I have to that.

Now, the original part of your question——

Mr. SCHEUER. Would your program get more people down there? I notice you mention you have medical schools in underserved areas, urban and rural. That doesn't mean the doctors are going to serve in the underserved area.

Dr. Parrott. That is not built into the bill, because there is no requirement to redistribute the doctors in this bill.

Mr. Scheuer. Are there any incentives for doctors?

Dr. Parrott. Yes; I think we build incentives, but I think it has to be done on a practical level. You must take them out to the rural area in groups or they must be covered in some way in order to screen people. I think that is off the subject of the bill.

Mr. Peterson. A further incentive would be the fact they would be providing the availability of insurance coverage to everyone so that in all areas there would be the availability of that coverage.

Now with respect to the distribution, I think one of the many proposals that certainly your committee has fostered and we have supported very strongly is the National Health Service Corps. That is the program which is designed outside of any national health insurance bill, but it's a primary one to seek to put physicians in the shortage areas and we would continue to support that very strongly, as we have in the past.

Mr. Maguire. Could we—I don't know if there is data readily available on the Bell Curve that we are talking about. Is that something that could be provided to the subcommittee?

Dr. Parrott. These are profiles. I think the governments have had access to them at times. When the Blues became fiscal intermediaries for medicare they ran profiles on the physicians which we were told was going to stay there.

Mr. Maguire. I will check on that and get back.

Dr. Parrott. I think the Government has access to the profiles through medicare.

Mr. Maguire. The fact remains, under your proposal, the usual customary and reasonable fee could be determined for procedure.

Dr. Parrott. Yes, sir, in any given area.

Mr. Maguire. And the insurance company would then reimburse to that point but that would not prevent, would it, the doctor from charging the patient directly an additional charge?

Dr. Parrott. The doctor under medicare which we are not talking about.

Mr. Maguire. I am asking about under your bill.

He could still charge that additional fee if he wished to.

Dr. Parrott. Well his contract is basically, you know, when you are taking care, what you are trying to talk about is full service insurance as against indemnity insurance.

Mr. Maguire. Answer the question, under the bill can the doctor make additional charges directly to the patient?

Dr. Parrott. I presume he can if it's within reason.

Mr. Maguire. That is one of the problems. Thirty percent of the dollars paid in this country by individuals for personal health care, as I understand it, comes out of a person's pocket. That is something I am concerned about; that impacts people in a very serious way. We still have a situation under your bill where the additional charges, in any amount, can be assessed on the patient directly above what is usual and customary.

Mr. Peterson. If I can comment, even if we assume the 30-percent figure is correct, that may include those individuals who do not have insurance in the first place; and it may include individuals who are paying out-of-pocket expenses for full coverage which is not under the insurance. So I don't think——

Mr. MAGUIRE. But that is simply a way of saying that people aren't properly covered in this country at the present time?

Mr. PETERSON. There is no qestion about that.

Mr. MAGUIRE. Is there any indication that in your bill the people necessarily would achieve better coverage?

Dr. PARROTT. You will get a better insurance package.

Mr. PETERSON. The whole purpose is to provide a comprehensive package to the people.

Mr. MAGUIRE. It's still on a voluntary basis, so they may decide against their better interest.

Mr. PETERSON. I can't conceive it would be against their better interest to acquire the comprehensive coverage when they are assisted by the Federal Government in its acquisition and particularly for the low income where they are subsidized entirely, there is full incentive.

I would like to go back for a moment to your earlier comment on usual, customary, and reasonable.

That formula or concept is embodied even in the medicare program, and that is the basis on which the determination for payment is made in that program.

Mr. MAGUIRE. I know they have all been disastrous. I agree with that.

Dr. PARROTT. Congressman, only a part of the overrun on medicare was a medical overrun. A very small part of your overrun is in the institutions, and institutions have a labor problem.

Now, you can't get around that; that's a fact and any innuendo that the medical profession has a big part in the overrun is not so.

Mr. MAGUIRE. I don't think there was any innuendo suggested or implied.

May I ask about the question of second consultations that has frequently been mentioned as a way of leaving the fee schedule question to the side for the moment.

If you solve the fee problem you still have the question of whether or not it's necessary to do certain things at certain times, is a second consultation approach in your judgment a good way of providing additional restraint or constraint on the kind of procedures that may be necessarily performed, unnecessarily if there are such? Would you endorse the concept?

Dr. PARROTT. No, I don't think the second man has necessarily any expertise over and above the first man.

How are you going to pick the second man? Then if he disagrees, what are you going to do, pick a third man?

Mr. MAGUIRE. I think that would be the very logical thing to do.

Dr. PARROTT. Are you going to say that is going to cost less?

Mr. MAGUIRE. Well, it depends on how often you think unnecessary procedures are being performed and what the costs of those procedures are, I am asking the question——

Dr. PARROTT. I know. The question that I have then is what is unnecessary? It's a judgment definition.

Mr. MAGUIRE. As I understand, the College of Surgeons in their study suggested there was too much surgery and that we ought to cut down on that.

One way to do that is to have second consultations. I take it you don't favor that?

Dr. Parrott. Well I don't know what hard data the College of Surgeons had but there was a recent study in Brooklyn, in Long Island, by a Dr. Emerson that indicated through a very concerted study, of 800-odd elective surgical cases, less than 1 percent could be judged unjustified.

So I think it depends on what data you are talking about.

I am not sure we have the proper data bank on a proper basis.

Mr. Maguire. One final question, then I have to go to the floor.

PSRO's obviously can't look over the shoulder of every doctor every time he asks for a fee to serve his patient?

Dr. Parrott. That is correct.

Mr. Maguire. Why isn't a prepaid arrangement much more desirable which encourages——

Dr. Parrott. Because it has——

Mr. Maguire. Efficiency and discourages unnecessary procedures and excessive cost.

Dr. Parrott. It also encourages neglect. It also is rigid and has a very definite impediment, in referral. Most closed panel setups have a very rigid system of intergroup referral, and it doesn't always give you the best person to refer to.

Our only argument would be if the patient likes it, fine, but we don't need it poured down in concrete in one direction for the whole delivery system.

Mr. Maguire. Your earlier comment, this leads back to the Kaiser plan, they were underutilizing.

Dr. Parrott. That is right.

Mr. Maguire. Hospital beds?

Dr. Parrott. That is right.

Mr. Maguire. Is that tantamount to saying they are not giving proper treatment to people who are ill?

Dr. Parrott. No, but I think they make it more difficult for the person to get treatment.

Mr. Maguire. And, therefore, the person doesn't get the treatment the person needs.

Dr. Parrott. In many cases they don't get the treatment there.

Mr. Scheuer. Dr. Parrott, it's 7 minutes to 6 and you have had a very rigorous examination and cross-examination here. I think you have been very helpful to us and I just have a few questions.

In your package do you include ambulatory care. What effect do you think the inclusion of ambulatory care will have on the number of physician visits, and, absent any efforts at cost control over the fees that physicians charge, what effect will this have on escalation of medical costs based on number of physicians visits and the fees physicians charge?

Dr. Parrott. I think——

Mr. Scheuer. In other words, don't you worry about the same abuses happening in terms of number of visits and physicians charges, as has happened in the escalating cost of medical care in hospitals?

Incidently, let me ask you this question before you answer the other question.

You stated that the escalation of medical costs have come largely through the crisis that we have been in.

Dr. PARROTT. Malpractice?

Mr. SCHEUER. Yes. That dates back 1 year or 2 or 3, but it's my recollection that the escalation of medical costs started almost a decade ago, in 1967 or thereabouts, when we commenced the medicare and medicaid programs. Isn't that really when——

Dr. PARROTT. Yes, the escalation started there along with everything else.

Mr. SCHEUER. Right. Wasn't that largely due to the fact that we didn't control hospital visits and didn't control fees for various services?

Now you are including ambulatory care in your package. I am pleased that you are doing it. It seems to me we have to have a shift away from hospital care to outpatient care on an ambulatory basis and also home care.

But if you don't control costs, if you are not willing to have any kind of supervision of physicians cost, don't you feel that there is a predictable likelihood that you will have the same kind of abuses caused by number of visits and fees charged for those visits as we went through in the last decade reflected by the incredible escalation of hospital care costs?

Dr. PARROTT. Well, I would like to put this in context if I can: The Physicians cost escalated at about the same rate as the cost of living until medicare. Then it went up about 2 percent per year until the inflationary spiral took over and we had, you remember, phase 1, 2, 3, and 3½. Fees were held down then because they were forced down, and then there was a jump right after that, as there always is when you come off controls.

And then we haven't got the reflection of the whole jump yet in malpractice.

The premiums are skyrocketing faster than you can adjust to, and believe me this is the No. 1 priority of organized medicine, to do something about that as quick as we can, but it's a very complicated problem.

When you get a problem like you had with the Federal employees here in the District, and suddenly offer a benefit that they didn't have, like you made the poor with an insurance policy, you may get an overloading of the system, and you may have a problem with a supply and demand until you get adjusted to it.

So I would say, yes, there may be some maladjustment to start with but I think it can be adjusted.

Mr. SCHEUER. How can it be adjusted?

Dr. PARROTT. Well, I——

Mr. SCHEUER. What system would you apply to control it?

Dr. PARROTT. I don't think you have to control everything. I think you can control some things by education.

Mr. SCHEUER. We sure as the devil haven't controlled the physician's office fees and unecessary hospitalization.

Dr. PARROTT. You haven't controlled inflation either.

Mr. SCHEUER. No; but the escalations in medical costs have far outraced the general level of inflation by far.

Mr. PETERSON. If I could comment on that just to relate figures that go back to the beginning of the economic stability program in 1971: From that period up until the present time—by present time I am going back to September of this year—over that period of time physicians' fees have increased 31.8 percent.

All service items have increased 30.7 percent. Only 1 percent difference.

Legal services have increased 41 percent over that period.

I just want to put in context the increase of physicians' fees in relationship to all other services under the Consumer Price Index since that period.

Mr. SCHEUER. Mr. Peterson, you and I are both lawyers, we know that legal fees are always justified.

Mr. PETERSON. Reasonable and customary.

Mr. SCHEUER. Right.

Dr. PARROTT. Are you going to take the reasonable out?

Mr. SCHEUER. I noticed that you have no coinsurance for incomes under $4,200. I come from New York City where $4,200 constitutes instant starvation for a family of four.

Have you thought about what would be a reasonable level of cutoff for coinsurance in a northern urban area?

Mr. PETERSON. What figure would you like to suggest?

Mr. SCHEUER. What is the poverty figure for a family of four in New York?

Mr. PETERSON. Forty-five is very close to $4,200 so there is no difference.

Let's extend that so we understand the formula because it's a little confusing and misunderstood by many people.

Starting at this $4,200, the coinsurance limit for that group is only 10 percent of the income above that. So even if you have a $6,000 family your total coinsurance limit is not $2,000 but it would be $180.

So it's related directly to the income.

When the income reaches a certain point then the $2,000 is a fixed limit for everyone.

Mr. SCHEUER. You may know that recently there was a court case that held that lawyers could advertise their fees. The effort of the bar associations to prevent that constituted a violation of the antitrust statutes, I think, and bar associations are now moving toward permitting lawyers to advertise and state their fees for specific legal functions.

Do you feel that would be a constructive approach for the medical profession?

Dr. PARROTT. Well, I think that is something that Mr. Nader has advocated, posting of fees and one thing and another. I don't think it probably would be good for either profession because a person setting a fee on a thing as complicated as a service doesn't necessarily mean he is getting dollar value, and I would have a hard time saying, while it may give a person a false sense of security if he goes for the highest priced guy, that he is getting the best care. And if you go for the lowest guy you may not be getting the worst care in the world either.

Again, it has to come back in anything as complicated as services, such as legal services or medical services, to where you almost have to judge it on a one-by-one basis on the person's personal problem and how he reacts to it. And this is one of our arguments concerning the rigidity of some programs, that the humanism and the way medicine is practiced is at stake in many of those bills where the system becomes so rigid you don't have enough variables or variability in your activity to fit the treatment to the patient.

Mr. SCHEUER. Well, I am not talking about being rigid, I am talking about being more flexible in giving the patient, the consumer, more information than they have now and letting them judge between competing doctors. Undoubtedly cost would be just one element that they put in their mental computer. They would consider the physician's reputation and his affiliations with hospitals and past experience, general reputation in the community. He certainly would have more information.

Mr. PETERSON. I don't know exactly what kind of advertising you may have in mind, Mr. Scheuer, whether you are considering newspaper ads or whether that would be desirable from the standpoint of even the patient.

But certainly the association has always advocated the physician should discuss with his patient in advance the fees that are to be entailed in regard to any service.

In my own experience recently in going to a physician's office, there was a sign on the wall which indicated that the fees for the services were available upon request for the major services that were performed in that office.

Mr. SCHEUER. Why wouldn't they post them?

Wouldn't it be a good idea to post those fees?

Mr. PETERSON. I think it accomplishes the same thing. That would be a matter perhaps of some policy there, I am not sure.

We have, of course, the matter of ethics and I think this may be a better determination at the local level as far as medical societies at the local level.

Mr. SCHEUER. Do you think it may be a good idea to vary it from State to State?

Mr. PETERSON. What consideration my be involved I am not sure. It is something we will look into.

Mr. SCHEUER. How can considerations vary from county to county?

Mr. PETERSON. I am saying there may be policies involved in the State with respect to any legalities that may be involved or variations involved in State regulations.

I am not sure I recognize the suit that you are referring to. I think—wasn't it a Virginia——

Mr. SCHEUER. As a matter of public policy might not there be clear advantage to the consuming public to know they could call a legal office and ask how much is charged for a closing or how much is charged for a divorce, or how much is charged for an adoption, or how much is charged for a simple contract?

Dr. PARROTT. They do this all the time as far as obstetrics are concerned. My girl gets a call every day, what is your price for delivery? The girl tells her. Some appear and some don't. They are shopping. And I think they can do that now. The problem I think with posting is that it causes a type of competition that may become very unprofessional, after all, we don't go out and hawk oranges and lemons like the street vendors and if you get into that kind of a problem I don't think it gives a good ethical background.

Mr. SCHEUER. How could it become unprofessional and——

Dr. **Parrott**. What you are looking for is a price war in medicine.

Mr. **Scheuer**. I am looking for the consumer to have that information available as well as all the other information. The consumer would inquire about the reputation of the doctors. The doctors may want to compete on price. Assuming all things being equal, there are half a dozen gynecologists who could deliver the infants. Why shouldn't the consumer have price as one of the elements of making this choice?

Dr. **Parrott**. It's available on request. I don't know why you need to carry it to advertising. All you need to do is request it.

Mr. **Carter**. I would like to make a remark or so.

I take it the gentleman would suggest physicians and surgeons particularly would have on their walls appendectomy, $250, surgeons fee for tonsillectomy, $75; proctoscopy, $25, bronchoscopy, $125, all cases of syphilis are treated for $1,000, gonorrhea treated for $100, undulant fever, $750, tulerema, $500, tabes dorsalis—sorry, we can't treat that, that has already occurred. It's an end result.

Mr. **Scheuer**. I think that sounds like a very sound approach.

Mr. **Carter**. Really, it certainly would be telling the truth about some things if we put down the actual charges.

Mr. **Scheuer**. The truth might be the best medicine for a lot of ailments.

Mr. **Carter**. I would agree to that.

Now, one thing that I was very much interested in was your way of financing. I believe you charged 3 percent of the earnings of companies; is that correct? You take 3 percent of the earnings and put that into a particular fund?

Dr. **Parrott**. When it works a hardship on the companies——

Mr. **Carter**. That is the point, when it works a hardship on a company you do what?

Mr. **Peterson**. Mr. Carter, that 3 percent relates to the subsidy that is provided to employers who do incur an increased cost in their cost.

Mr. **Carter**. To keep them from falling. I have in mind particularly the small businessman.

Mr. **Peterson**. That is right.

Mr. **Carter**. Who couldn't take care of all of these things.

Mr. **Peterson**. He would be eligible for a subsidy then if his costs increased over 3 percent.

Mr. **Carter**. At this time it's just so important that we keep these people in mind because some of them are failing now. We could break them and we don't want to do that, particularly. I'm not referring to some of our wealthy concerns, our huge oil companies or huge building owners, and so on, but it's the little people, that is whom I am talking about; small business. I want to compliment you on that. As I said before, this bill appears increasingly beneficial as one studies it.

Thank you. Mr. Chairman.

Mr. **Rogers**. Could you just tell me quickly, of all of the systems you have looked at over the world, which do you think have functioned the best with universal medical care? England, Sweden, Denmark, Canada, does Russia, China——

Dr. PARROTT. Well, I don't know that I have any data on Russia and China. We have quite a bit of historical information on Western Europe.

Unfortunately it's hard to compare Western Europe to the United States. First off, they are divided up into small homogeneous countries.

Mr. ROGERS. I was not saying which necessarily would be best for us. I was saying, where do you think the system has worked the best?

Dr. PARROTT. In the world?

Mr. ROGERS. Yes.

Dr. PARROTT. Right here.

Mr. ROGERS. But we don't have universal health care here.

Dr. PARROTT. Well, obviously it didn't work too well in Britain on the long haul, and it didn't work. The problem that I see in Western Europe is that every medical society I have talked to in Western Europe is a syndicate, they are a labor union, and certainly we do not propose to try to get into that kind of a problem here.

We may have to negotiate with Government agencies and governments, but I would hate to see anything resembling a universal type of job action in this country.

Mr. CARTER. Mr. Chairman, would you yield on that.

Actually aren't the people being taken care of? Or are they being turned away from our hospitals?

Dr. PARROTT. You mean our hospitals?

Mr. CARTER. Yes.

Dr. PARROTT. No, I don't think they are.

Mr. CARTER. Are the poor being taken care of? What about youngsters who have dreaded diseases such as cancer, for instance? Isn't it true that there is a plan even now by which they can get into the cancer clinics throughout our country and have their treatment taken care of and assisted by the Cancer Society?

Isn't that quite true?

Dr. PARROTT. That is true.

Mr. CARTER. Yes, sir.

Dr. PARROTT. I would like to add to that, you know, Dr. Carter, the same as I do that a person in this country can walk into any emergency room and be taken care of even if he goes on bad paper, and that is a form of charity.

But the problem is, our big problem on access is a cultural problem of getting into the system, not a financial problem, it's a cultural problem. Its inability to know how to get into the system or thinking that finance is going to cause a turndown or a turnaway.

They may be referred away from some physicians offices, that may be true, but I don't know of any major community hospital in the United States where a sick person walks into the emergency room that they are not taken care of.

Mr. CARTER. Would you turn down a maternity case, if a woman came into the hospital without funds and you were there?

Dr. PARROTT. We never have. If we are called on to take care of the patient, we never have turned them down.

Mr. CARTER. I don't think that any self-respecting doctor would. Perhaps the same percentage, 3 percent of our profession, is like 3 percent of almost all other professions. None of us is perfect. The only perfect man was crucified.

Thank you, Mr. Chairman.

Mr. ROGERS. Well, then, evidently we don't have any problem except an education problem. Is that what you are saying?

Dr. PARROTT. Well, when you are talking about access, of course we have lots of problems. But——

Mr. ROGERS. I got that from the colloquy, that we don't have any problems at all. I wasn't sure that is what you meant.

Dr. PARROTT. The big problem in access, Congressman, is a cultural problem, and I think we have put too much emphasis on the horror stories. When the CBS story came out we found out the girl was well taken care of through agencies in existence.

Mr. ROGERS. I have in my personal experience people who have not been able to get it because of funding and so forth.

Mr. SCHEUER. Mr. Chairman.

Mr. ROGERS. I yield.

Mr. SCHEUER. Several times in your testimony you described our health care delivery system as the best in the world. I would like to question you about that.

I would presume that the best of our health care is equal to the best elsewhere in the world, and it may be better than the best in the world.

But there seems to be considerable evidence from morbidity and mortality statistics available that the average health care actually delivered through the system and enjoyed by the consumer is not as good as other countries that have health care systems. I am sure you are familiar with the morbidity and mortality statistics on health in Scandinavian countries and England and Canada.

I think in infant mortality we are way down 12th or 14th, and in heart disease, strokes, and other ailments we are far from the top. I think our life expectancy is not first in the world.

Now I am not attributing this entirely to defaults of the health service delivery system. It may be that some of the behavioral characteristics that you point out on page 16, as I recall of your testimony, have major impact there and that is one of the reasons I am so concerned with asking each of the witnesses what they think that we in this committee can do to impact behavior.

Having said all that, is there really any statistical evidence that will stand up that from the point of view of health outcome we are No. 1 in the world.

Dr. PARROTT. If you took the Swedes in the United States and compared them to the Swedes in Sweden you would find that the statistics are totally different.

The Swedes in Minnesota live longer than the Swedes in Sweden. Now, let me go to one other point.

You made a point of the paranatal mortality figures and people have done this often. You have to look at the way the statistics are reported.

In my State I have to describe anything that twitches at 18 weeks, abortions or miscarriages at 18 weeks, anything that moves or makes a movement is a live birth. This is not done in Sweden. Their home deliveries in Sweden are reported in the family. They have a totally different system of gathering statistics.

So what you are really comparing are apples and oranges. That doesn't deny the fact that the Swedish system in certain areas works very well. It does. Their research for example. The people in Britain that do the best work are very very good doctors. But even during the second World War—I spent 4 years in Britain before the health service there. I felt that we had more and better doctors per capita in this country than they had in Britain.

Nobody is taking on those countries as being backward or anything else. What we are trying to do is to avoid falling into traps that intelligent people fall into, and I think that is the most I can say.

Mr. Rogers. May I ask this.

I would agree that our doctors are well trained for the most part. Our care where people are getting it, our care is I would think the best in the world.

What we are looking at now is the system; how the delivery system works and how people serve it and who falls through the cracks, so-to-speak, and who doesn't.

I still would like you to answer, if you can, what nation do you feel has best organized itself to deliver health care in a universal care approach.

Dr. Parrott. I don't think I can answer the question, Congressman. I have never been in Sweden. I understand that they have an excellent system there from the people who have gone through but they have a lot of fault.

Mr. Rogers. I have never been there.

Dr. Parrott. Of what I saw in Germany, Munich, recently, they have two systems of insurance in Germany. I know the professor of obstetrics very well in Munich, and he took me to see his hospital. Those that purchase government insurance got care in one waiting room with a certain type of equipment and those in another that had private insurance got different care.

They had American power tables. I don't think they are that good but they are expensive. They have two systems, like the old system in the South where they took care of the blacks and whites. I told my friend that I didn't think you can sell this in the United States, and that we are just getting over that. He said he agreed.

He knows the United States very well, he is a world-known academician. But he didn't pussyfoot about it. He said they discriminate. I don't think we want to go for that kind of system. The French, I visited the French. The French have a very big labor negotiation problem between their medical societies and their government.

You talk to the government people, and they say there is no problem. You talk to the medical societies, and they say there are all kinds of problems, and they didn't speak English so I didn't get all the overtones.

Mr. Rogers. What do the people say there?

Dr. Parrott. Well, I can't answer that either because I don't speak French. I think the Dutch have a very complicated system but I will tell you this. As to the economics position in the negotiating countries, the Dutch, the Belgians and French, they have protected the economics of their dollars probably better than the rest of Europe, but that isn't what I think we are after either.

Mr. Rogers. What about Canada?

Dr. PARROTT. Well, you have to look at the Canadian system province by province. It's a totally different problem in Quebec than in British Columbia or Saskatchewan.

Mr. ROGERS. I realize it varies some. But overall——

Dr. PARROTT. If you talk to the people of a country who have lived under no other system of medicine, let's say, what do they have to compare with? They have waiting lists in Canada more than we do. The Vancouver General Hospital has a much longer waiting list than the hospital in Seattle a few years back. I haven't been up recently to check. They may have corrected or adjusted. To some extent the doctor's income in Canada is lower than is ours, but his overhead is not so high.

Again, there aren't very many people who have a feeling national pride who will come out and say the system stinks; it just doesn't happen.

The doctors talking in bull sessions as we have in the Northwest, will say, yes, they are unhappy with certain aspects of the system, but I am not prepared to judge the two systems.

Mr. SCHEUER. I think the closest we might come to that is to visit England where the doctors are unhappy, the public health people are unhappy, and consumers are unhappy.

Dr. PARROTT. Everybody is unhappy except Barbara Cassels.

Mr. SCHEUER. They are very frustrated and——

Mr. ROGERS. She's unhappy because she doesn't have enough money.

Mr. SCHEUER. With the generation of public health experience.

How about Australia and New Zealand?

Dr. PARROTT. New Zealand is more highly socialized than Australia. Again, I have never been down there. I think the Australian system works better than the New Zealand system because they have a lot more flexibility than the New Zealand area. That is what I hear from New Zealanders and Australians.

Mr. ROGERS. As I understand it, I think we can sum up by saying you are for national health insurance, you have presented a program.

Dr. PARROTT. I am for a certain type of——

Mr. ROGERS. I understand, you presented a certain type. You do believe in quality controls and some cost controls, as you have stated, and that you think every one ought to be covered?

Dr. PARROTT. Correct.

Mr. ROGERS. Thank you.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes.

Mr. CARTER. On emergency care, I should like to know how many other countries in the world use helicopters for evacuation of dangerously sick or wounded. Do you know of any?

Dr. PARROTT. Well, we are the only one.

Mr. CARTER. We use them here in our States.

Dr. PARROTT. Yes, we do in certain areas.

Mr. CARTER. Well in my State particularly, we have an excellent system.

Mr. SCHEUER. The West Germans do. We had a group of West German doctors that we had lunch with a few weeks ago. They described in elaborate detail their use of helicopters.

Dr. PARROTT. I think it's coming. It's an expensive ambulance, but it's changed the patient care.

Mr. SCHEUER. Mr. Chairman, I take it we are about to close this session?

Mr. ROGERS. Unless the gentleman has further questions.

Mr. SCHEUER. I want to thank the witnesses.

We have given them very much of a going over in depth and I would say the only other group that we have honored in this way was Leonard Woodcock of the AFL-CIO. He came here with two experts and I think it's a tribute to their ability to challenge us and stimulate us that we have had this long and indepth exchange and I appreciate it very much. You have been very patient and very informative.

Dr. PARROTT. Thank you, sir, and I hope anything we have said is not misunderstood.

Mr. ROGERS. We appreciate very much your being here and your very helpful testimony. As we go into further hearings at the beginning of next year we probably will want to come back and go into specific details.

We are trying now to get a broad brush feeling of the various significant proposals. Then we want to zero in on payments, zero in on benefits, zero in on delivery systems, by subject matter, and then we would like to get you to help us at that time.

Dr. PARROTT. Congressman Rogers, I would like to take this opportunity to offer to you and your committee the available resources of the American Medical Association. We have one of the best medical libraries. We have a good system of statistics and I would like to offer any of the resources that we have to your committee. We would be glad to supply information on request.

Mr. ROGERS. You are very kind. I am sure we will call on you.

Incidentally, we also wish to express the committee's appreciation for your help with the staff in preparing the dictionary of terms. We are grateful to you for that.

Dr. PARROTT. Thank you.

Mr. ROGERS. Thank you for being here.

The committee stands adjourned.

[The following statements and letters were received for the record:]

STATEMENT OF THE LOUISIANA STATE MEDICAL SOCIETY

Mr. Chairman and members of the Subcommittee on Public Health and Environment of the House Interstate and Foreign Commerce Committee, the Louisiana State Medical Society is happy to have this opportunity to present its views on National Health Insurance.

The Louisiana State Medical Society has been, since its founding in 1878, an organization dedicated to bringing the best medical care possible to all citizens regardless of ther ability to pay. The Louisiana State Medical Society has been and remains equally dedicated to the concept of medical service as a proper function of the private sector.

The more than 3,500 members of our Society believe that the ony way that we can continue to provide adequate, high quality health care for all citizens is by practicing our profession within the framework of the American free enterprise system with the least possible interference by government. We present our statement in OPPOSITION to any and all of the National Health Insurance proposals that have to date been put forth.

I. GOVERNMENT CANNOT GUARANTEE HEALTH CARE

Neither the government, physicians, nor anyone else can guarantee health or provide health care in unlimited quantities. This is a fact. According to Stanford University economist Victor R. Fuchs, all of the decisions about medical care, such as producing more doctors, building more hospitals, having more sophisticated equipment and even having National Health Insurance, will have far less impact on the nation's health than will the personal decisions made by American citizens. This view has recently been echoed by Theodore Cooper, M.D., Assistant Secretary of Health of the Department of Health, Education and Welfare.

National Health Insurance will not lower many of the leading causes of death, such as accidents, suicides, homicides, coronary heart disease, etc. These causes of death and poor health care are results of individual decisions regarding personal life styles, such as whether to smoke, lose weight, control high blood pressure or consume less alcohol.

Economist Fuchs says that many statements about the "right to health" are misleading because they "suggest that society has a supply of 'health' stored away which it can give to individuals and that it is only the niggardliness of the Administration or the ineptitude of Congress or the selfishness of physicians that prevents this from happening."

Fuchs further emphasizes the view that all people cannot have everything they would like to have. He reasons that there simply are not enough natural and man-made resources available to satisfy all human wants from education to social justice. He states that although there are inefficiencies and wastes in the present system, that even if there were eliminated that this nation's resources would still be short of meeting such unlimited demands. While we do not agree with everything Fuchs states in his book, entitled "Who Shall Live," we feel that it demonstrates that even the most lavish use of medical care will not make a great difference in the nation's mortality rate, but will only lead to national bankruptcy.

II. LEGISLATION

There were more than a dozen major NHI proposals introduced in the last Congress. Many of these proposals have been revised and introduced in the 94th Congress and undoubtedly more can be expected.

Those considered to be "major" NHI proposals are:

H.R. 6222 (Reps. Fulton, Carter, Duncan (Tenn.) and Murphy (N.Y.)), "The Comprehensive Health Care Insurance Act of 1975" (the AMA Plan).

H.R. 1 (Rep. Ullman), "The National Health Care Services Reorganization and Financing Act" (the AHAA Plan).

H.R. 5990 (Rep. Burleson); S. 1438 (Sen. McIntyre), "The National Health Financing Act" (the AHA Plan).

H.R. 21 (Rep. Corman); S. 3 (Sen. Kennedy), "The Health Security Act" (Committee for National Health Insurance Plan).

S. 2470 (Sens. Long & Ribicoff), "Catastrophic Health Insurance and Medical Assistance Reform Act."

III. COST

All of the above NHI plans would have the government provide health care for the non-needy and would cost untold billions. The authors and sponsors of each proposal have submitted cost estimates which we will not go into. We will only point out what has happened with estimated costs in the past and what realistically can be expected with any NHI plan.

In the early 1960's when Medicare was being debated in the Congress, its proponents estimated the cost would be $900 million for 1965 and gradually build up to $1.7 billion in 1975. Those who opposed Medicare estimated it would cost several times what the proponents said it would. The actual figures show that the cost of Medicare for 1965 was $3.5 billion and rose to $14.9 billion for 1975, a 900 percent cost overrun!

If a 900 percent cost overrun on a limited program like Medicare and Medicaid resulted, we can only look to our English cousins for a realistic prediction of what would happen here if we enacted NHI. The actual figures show that NHI in Great Britain is costing 1,700 percent more than its proponents said it would when it was enacted in 1948.

IV. LOWER QUALITY CARE

The Congress should reject NHI not only because the staggering cost would bankrupt the nation, but because it would result in poorer quality health care for all. The proponents of NHI will dispute this by citing fallacious statistics that purport to show that some other countries with socialized medicine have lower death and birth rates than the U.S. Rather than bore the committee with a deailed rebuttal of international health statistical data, we will only say these folks are comparing apples with oranges. A simple explanation of this data can be found in Chapter II of "The Case for American Medicine, A Realistic Look at Our Health Care System," by Mr. Harry Schwartz of the New York Times, published by David McKay Company, Inc. in 1972. We commend this book to the committee and to anyone who is interested in the subject of NHI.

V. EXPERIENCE IN ENGLAND

As to the quality and availability of health services under NHI, we need only study what has happened in England since 1947. While some of the plans proposed to Congress are not as all-encompassing as the British system, there is no doubt that if the Congress accepts any plan it will be expanded as time goes by as witnessed by Social Security, welfare programs, food stamps, etc. This is the nature of political and government programs.

Recently, a number of members of the House of Representatives, including Representative David E. Satterfield, III of this committee, had an opportunity to view NHI in depth in Britain as guests of the Congress of County Medical Societies. It is unfortunate that all members of the Congress could not have the same opportunity to view first hand NHI in operation before voting on this vital issue.

For those members of Congress who have not personally inspected the British system of NHI, we commend the series on "Britain's Unhealthy Health Services" that began in the September, 1975 PRIVATE PRACTICE magazine to their attention.

VI. ASSIST ONLY THOSE IN NEED

As for our great country, the Louisiana State Medical Society recognizes that people of all ages and all incomes have health and medical problems. Our profession is dedicated to helping people overcome these problems. We fully realize that some of these problems are financial. However, to solve these few problem areas, we do not feel it is a sound or an American concept to enact any kind of compulsory health legislation. The Congress should address itself to the problem of assisting those, and only those, who cannot care for or help themselves in meeting their health care costs.

VII. CONTROL COSTS

All consideration of further financing of health care by government as a function of the public sector must be discarded as pure folly. We must realize that federal programs geared to "zero cost" with unlimited consumption potenial will raise such demands that all of the resources of this rich nation will not be able to cope with the demand.

A responsible action for this committee would be to reverse present trends, to turn back to the private sector the function of health care. A legitimate start would be to offer no public assistance to any citizen who does not need it. If Medicare alone was restructured to pay the cost for only the needy, massive savings to the government would result, and lessened pressure on the medical care system would occur overnight.

The next step would be to raise the cost for entry into the system for all as a method to control overutilization. If even the poor would be made to pay something, even a token amount, they too would be concerned about cost. A further method of controlling cost would be direct billing, front-end deductibles and co-payments rather than blank checks.

VIII. CATASTROPHIC ILLNESSES

As to concerns expressed about the costs of catastrophic illnesses, this can be met by the existing private insurance market. Catastrophic illness is an insurable risk because it is rare and the risk can be spread widely. Already private carriers have available almost unlimited coverage above a higher

($2,300) front-end deductible for a family of four for the cost of a package of cigarettes per day. The only legislation that may be needed in this area is to guarantee the availability of this coverage to all regardless of previous medical history.

If the Department of HEW and other federal agencies, that spend untold millions promoting the utilization and often overutilization by ineligibles of existing programs, would instead devote this effort and expense to making known the availability and low cost of catastrophic health insurance, it would perform a real service, lower dependency on government and help establish credibility in government.

IX. CONCLUSION

1. There is no real need for NHI.
2. NHI would lower the existing standards of medical and health care.
3. NHI would provide care for those who can afford to care for themselves.
4. The cost of NHI would bankrupt the nation.
5. Any form of NHI, no matter how limited, would gradually be expanded into a total system of socialized medicine.

Statement of Optical Manufacturers Association

The Optical Manufacturers Association is pleased to have the opportunity to submit this statement with regard to national health insurance.

The Optical Manufacturers Association (OMA) is the only national association of manufacturers of ophthalmic frames, ophthalmic lens blanks, semi-finished and finished glass and plastic ophthalmic lenses, ophthalmic cases and ophthalmic machinery in the United States. Our association represents more than 90 percent of the products manufactured in the United States which falls in the above categories. Our industry is centered in the northeast but has manufacturing plants located across the country. We are an old industry and our product is one that has been used by the consumer for centuries. In America, Benjamin Franklin was one of our earliest pioneers inventing the predecessor to the modern multifocal ophthalmic lenses.

Today, it is estimated that over 110 million Americans, half of our population, wear some type of prescription eyewear. Eyeglasses are probably the most widely used medical device in the world. It is a device that everyone is familiar with and can be found in almost every home.

Eyeglasses correct vision so that the wearer can see better and thus function better in his environment. Eyeglasses enable students to study better; workers to work more efficiently; drivers to see the road and all of us to improve our safety and comfort in every way.

When the question of national health insurance first became a real issue for members of OMA, a substantial question was raised as to whether or not this concept was in the best interest of our nation and the millions of eyeglass wearers. Since that time the pros and cons of the various national health insurance bills have been widely debated and it would be of no value to repeat such a debate in this statement. It appears to OMA that some type of national health insurance will be enacted by the Congress and that such a proposal will include eye care and eyewear. We therefore would like to limit our discussion to the question of how Congress can best implement a conclusion to include eyewear and eye care as a part of national health insurance.

The past ten years has seen a tremendous increase in the adoption by the consumer of prescription eyewear as a fashion aid and a vision aid. At one time eyeglasses were considered an opprobrium. The child who appeared on the playground with his eyeglasses was subject to ridicule.

Today eyeglasses are being featured by fashion magazines and the couturier as the "in" thing. The child of today appears on the playground with a smartly styled aviator frame or a multi-colored high-style frame and is envied rather than ridiculed. Through many excellent early diagnostic programs run by school systems and professional groups, we are catching visual deficiencies at an early age and thus are better able to help school children fully develop their potential. Men and women are less reticent to wear glasses in public and indeed often use glasses for both vision and fashion purposes. The benefits of this greater acceptance of prescription eyewear is easily apparent. People who see better work better, study better, and, indeed, live safer lives.

The inclusion of eye care and eyewear in national health insurance will bring eyewear to even more people. However, at the same time, the consumer should be given a freedom of choice on how to best spend his eyewear dollar.

Freedom of choice would permit consumers a definite eyewear allotment that could be used as the consumer sees fit either to purchase a standard type of eyewear or alternatively to supplement the allotment with additional monies to purchase eyewear that the consumer might find esthetically more to his liking.

The following language would accomplish the freedom of choice goal:

"Covered eyecare and eyewear services, including the furnishing of ophthalmic frames, lenses and cases as provided in Section —, may be obtained by the insured from the eye practitioner and/or optician selected by the insured provided that the costs thereof shall not exceed the schedules set forth under the regulations to be issued hereunder. These regulations will provide maximum allowable costs to be paid for the eyecare and eyewear so defined, but in no case restrict the right of the eligible individual to select the eye practitioner and/or optician of his choice or eyewear (lens, frame, case) qualifying under Section —. It is recognized that in certain instances the cost of the eye care or eyewear may be greater than allowances provided and in such instances, the insured will be permitted to utilize the allowances toward defraying the total cost."

National Health Insurance will extend comprehensive eye care to millions who today may be receiving only marginal attention or possibly no attention at all. This extension of eye care services will also require a means of providing the consumer with high quality ophthalmic materials that meets the exacting standards imposed by the Food and Drug Administration. Yet eyeglasses are more than a mere functional device. Eyeglasses are a tremendously important expression of the individual taste of each person who wears them.

In today's society, most consumers are conscious of their own appearance. Obviously the eyeglasses one wears has a direct affect on appearance.

Thus, Congress is faced with a problem. There is presently a wide variety in style and price of eyeglasses available to the average consumer. In certain cases, lower priced eyewear may adequately provide for a consumer's visual needs and yet not satisfy his personal requirements with regard to appearance and style.

Congress is well qualified to substantiate that 110 million plus American consumers will not all accept the identical style eyewear. Eyewear must permit an expression of individual tastes and not become some type of government sponsored uniform.

Congress must also recognize that there should be proper limits on the cost of every part of National Health Insurance. With regard to our segment of this legislation, Congress is attempting to provide comprehensive eye care to all people in our country. In this context it is obviously not the purpose of National Health Insurance to give every man, woman and child the right to an individually designed eyeglass frame personally created for him or her. The expense of such an alternative would be astronomical and functionally unsupportable.

"Freedom of Choice" is the concept that satisfies the purpose of National Health Insurance legislation and at the same time meets the needs of the people with regard to individuality, appearance and style. These needs should not be ignored. In the year of our bicentennial it is well to remember that our nation was founded by those who wished to guarantee to all persons the right of individual expression in a free enterprise economy.

By adopting the freedom of choice concept, Congress will guarantee that the consumer has the option to select the eyewear of his choice, and that the free enterprise system with full competition that is definitive of the ophthalmic industry is maintaind.

We strongly urge that the freedom of choice concept as set forth above be adopted.

STATEMENT OF ROYCE P. NOLAND, EXECUTIVE DIRECTOR, AMERICAN PHYSICAL THERAPY ASSOCIATION

RECOMMENDED NATIONAL HEALTH INSURANCE POLICIES RELATED TO PHYSICAL THERAPY SERVICES

The American Physical Therapy Association (APTA) is the national professional organizateion of 26,000 physical therapists who are licensed to practice in all of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

Physical therapy services

Physical therapy services contribute to the rehabilitation and expeditious recovery of patients disabled due to disease or injury, reduce the need for institutional care of the physically handicapped, and permit disabled individuals to achieve the maximum degree of independent living. Such health services are provided to patients in hospitals, long-term care facilities, health maintenance organizations, rehabilitation centers, patients' homes, and in the offices and clinics of physical therapists who are private practitioners.

APTA health care principles

The APTA has adopted seven principles that should be built into the program of the national health insurance which is approved by the Congress. These principles which relate to preventive health services, episodic health services and catastrophic illness health services are as follows:

The health care system should utilize existing public and private services, facilities, and agencies in ways that will economically make comprehensive health care available and accessible to all people.

Alternatives to existing methods and organizations for delivering health care should be encouraged when they demonstrate reasonable predictability of contributing to the availability and accessibility of comprehensive health care.

Preventive health care services and public education in personal health care should be made an integral part of the health care system.

The health care system should be accountable to the public and should include effective mechanisms for peer review, multidisciplinary review, and consumer participation in policy and audit of the system.

A sufficient number and variety of health care persons should be educated to meet continuing health care needs, and encouragement should be given to all health care personnel to provide services in areas of the nation where comprehensive health care may not be available.

The availability of health screening, preventive and early care, and timely referral for more extended care should be expanded by recognizing and enhancing the existing competencies of a variety of health care persons.

Methods of financing the health care system should take optimum advantage of both public and private funding mechanisms to support the full scope of health care and to remove inequitable barriers to receiving necessary health care services.

The right to health

Basic to the consideration of national health insurance is the premise that all of our citizens have the right to receive the health services they require. The Federal investment and involvement in making this right a reality through a program of national health insuranc entail responsibilities with respect to monitoring the availability of needed health services as well as their cost and quality.

Availability of health services

The ability to pay for needed health services is no assurance to the patient that the health services will be provided if adequate resources in terms of facilities and manpower are not available. The availability of health resources will be addressed through implementation of the National Health Planning and Resources Development Act of 1974.

More than geographic maldistribution is involved, however, in cases of availability and accessibility of health services for patients. Under Medicare and Medicaid, for example, patients are entitled to physical therapy services in skilled nursing facilities. A recent HEW study, "Long-Term Care Facility Improvement Study," revealed that about "70 percent of the patients needing physical therapy were not receiving it." Monitoring activities in the form of utilization review or professional services review organizations are needed if a high level of comprehensive health services is to be provided and if costs containments are to be realized.

The failure to provide physical therapy services to patients in need of such services in institutions results in extended institutional confinements and, ultimately, to excessive costs.

Acountability

Closely related to the issue of the availability of health services under national health insurance is the issue of the accountability of providers in terms of cost and the quality of care.

APTA urges that the availability of health services and the accountability of the providers for furnishing health services be assured through a program of evaluation that would consist of peer review and multidisciplinary review.

Multidisciplinary review

The national health insurance program approved by Congress should provide for a multidisciplinary program of utilization review with the objective of achieving the optimum realization of health resources. Under Medicare, utilization review focuses primarily on reducing the length of hospital stay, although the quality of care is also a stated objective. Multidisciplinary review offers a significant potential for savings under national health insurance and improving the quality of care by reviewing the need for such health services as physical therapy and the appropriateness of the provider setting for needed health services.

APTA recommends that national health insurance adopt a multidisciplinary review program to ensure that physical therapy and other health services are provided when they are needed and are not provided when they are not needed.

Peer review

The program of multidisciplinary review under national health insurance should be complemented by a program of peer review. Such a program would evaluate the performance of recommended services following the recognition that such services were indicated and needed. In the case of physical therapy the peer review process would focus on such aspects as productivity, staffing standards, quality assurance, and reasonable cost.

Conclusion

The functions of planning and evaluation are essential to the health care system in terms of not only the availability of health services but also their quality and cost. A national health planning effort is now underway with the implementation of Public Law 93–641, the National Health Planning and Health Resources Development Act of 1974. The same national commitment to evaluation should be provided for through national health insurance.

STATEMENT OF MICHAEL F. DOODY, PRESIDENT, AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

This statement presented by Michael F. Doody, President, the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068. The American Osteopathic Hospital Association represents 210 osteopathic hospitals in this country.

INTRODUCTION

The American Osteopathic Hospital Association has been seriously considering the effects of a national health insurance program for the past several years. The considerations have dealt basically with the best possible manner to implement such a program so that all Americans can be assured the highest quality of health care, and at the same time the mechanisms that will best assure an important segment of our health system—the hospital—the freedoms and ability to adopt and implement those programs to best meet the needs of local areas and communities.

In our committees and task forces over this period of time, the prevailing consideration was quality patient care and its efficient and effective delivery under a national health program. We have reviewed alternate proposals carefully and have seen pitfalls and barriers we hope are avoidable in any national program enacted in this country. Rather than a singular issue of national health insurance, we have chosen the broader spectrum of a national health program that pulls together a number of important factors—manpower, financing and the basic freedom of choice in the health marketplace—all of which we believe are important to a posture on a national health program.

This statement is made on behalf of all osteopathic hospitals in the nation. In 1974, osteopathic hospitals provided 6.4 million patient days of service. These are people who choose to be served by an osteopathic physician. As individuals they make that choice and as Americans they are entitled to the freedom of that choice. To interfere in any way with that choice would be unthinkable.

In total, there are approximately 25,000 osteopathic hospital beds in the nation. The 210 osteopathic hospitals will spend over $900 million this year in expenses involved with the care of their patients. The major role and objective of osteopathic hospitals and physicians, for the most part, is primary health care. That is, the bulk of the 15,000 osteopathic physicians who are now practicing in this country are family physicians who consider themselves, for the most part, as general practitioners specializing in primary care services.

It has been estimated that osteopathic physicians and osteopathic hospitals, which represent less than 5 percent of the total number of physicians and less than 4 percent of the total community hospital component in this country, deliver primary health care to 10 percent of the population. In many areas in the 27 states in which there is an osteopathic hospital, it is the only hospital in a wide geographic region, indicating that osteopathic hospitals and physicians are located in rural and semi-rural areas.

A NATIONAL HEALTH PROGRAM AND ITS GOAL

We have chosen to view the total health picture in the nation rather than the isolated segment of a national health insurance plan. Our view should not be construed as minimizing the importance of health care services for all, but today we are concerned with the context in which such a plan is considered and developed.

We intend here to discuss the following elements of a total health care program and hope that each facet of this proposal will gain your attention when viewing a health insurance plan: national health planning goals, certificate-of-need issues, malpractice insurance crisis, and the financing of a national health plan. Included as an appendix to this statement is our Association's Position Paper on a National Health Program, which we call to your attention.

Our Association strongly believes that the problems and crises in our health programs cannot be attached individually for they are in fact interrelated and interinvolved. The quick and easy solution in one area may well cause problems elsewhere in the total picture, and consequently it has been our feeling that although national health insurance in itself may solve some problems, it may well create others. This testimony does not present a panacea for all of the problems confronting the health fields. Rather, it attempts to give dimension and substance to many of the issues as viewed by the osteopathic hospital.

It should be clearly understood, and unequivocally stated, that we are in favor of a national health program, and we are encouraged that this Committee is taking time in this busy legislative session to begin consideration of this important and complex problem.

It is the purpose of this testimony to describe our position on the goals and objectives of a national health program and to present our best thinking on how those goals and objectives might be met most effectively. In the past many segments of the health industry were opposed to the concept of a national health program. Now, fortunately, the health field almost unanimously favors such a program but each views the methodology differently. We have tried to be as objective and realistic as possible in our views and to present here those elements that will fit best into the total health services represented by osteopathic medicine and osteopathic hospitals. Hopefully, they are as sound for all elements in the health field and the public at large.

We see the following as realistic goals of a national health program:

1. Universal coverage of health benefits for all Americans.
2. Availability, accessibility, and affordability of comprehensive health care for all Americans.
3. Comprehensive health care benefits that include: preventive, health maintenance and ambulatory care, all levels of patient care, mental health as well as catastrophic health benefits.
4. Appropriate and adequate financing of such a comprehensive program.

Importantly, the national health program should be written and enacted with a minimum amount of regulatory provisions to allow the private sector, in open-market spirit, to develop the kinds of programs and delivery system to most adequately meet the needs of Americans as assured under the program. Specifically, the national program should dictate separate consideration for osteopathic facilities in certificate-of-need provisions. Individual practitioners of a recognized form of medicine and patients who choose their services should be permitted their freedom of choice already established and preserve those basic tenets of our system.

No national health program should mandate or in any way force an individual to seek health care from a provider other than one of his individual choice. By the same token, the program should assure a provider of health the explicit right to practice his profession in any manner or form consistent with his training.

The comprehensive benefits under a national health program should include the full scope of benefits now available from providers. The program should be an important move toward the elimination of any distinction between benefits for physical and mental illnesses.

We are realistic when we point out that the present health system may not be fully capable of providing the totality of health care benefits discussed here. We feel strongly, however, that the federal government has a responsibility to provide the necessary incentives and support for the health delivery system that will enable it to offer the full scope of benefits necessary in a national health program.

The position of the American Osteopathic Hospital Association is that a total range of benefits for health care should be included in a national health program. The ability to assure the delivery and financing of such benefits must be addressed immediately to make such a program realistic.

FINANCING A NATIONAL PROGRAM

Without question the major obstacle to any national health program is financing. The issues concerning the funds necessary to finance so broad a program are manifold and complex. Some hold to a Social Security tax, others to an establishment of standards and a voluntary mechanism, still others talk about the general federal tax revenues as the source of funding. All have merit and all need careful consideration.

We have come to some definite conclusions on the broad questions of financing. These conclusions are based on three general principles. First, all who can afford to pay for their coverage, or a portion of it, should do so. Second, multiple sources of financing should be utilized. Third, we feel strongly that the funds that are generated need to be adequate enough to assure providers of health care a sound financial base for their operations and for their orderly growth and expansion.

The weaknesses and disadvantages of the Social Security approach should be obvious to all at this point. Aside from the fact the Social Security Administration was not estabilshed to operate beyond the Social Security payments for retired Americans, attempts to have that agency do more than its intended objective have not proved successful. More importantly, however, we have learned some very hard lessons in the past few years regarding the increased role of the federal government in service programs. The growing federal deficit and, indeed, the fiscal problems of New York City are evidence that government should not attempt to assume the full, or even a major burden of financing social programs, when the private sector can be involved in such undertakings.

We believe that comprehensive benefits in a national health program can be established through a mandated insurance program whereby employers and employees share the cost. The burden of cost of such a program should not be borne totally through any form of tax, but rather, through a sharing by the employee and employer of the cost of an insurance program. The unemployed, the handicapped and the unemployable pose a problem that can be solved best through the federal government making direct purchase of coverage for these population segments just as an employer would do for his employees. It is necessary for us to add the point that we believe is essential here, i.e., an employed person may elect not to purchase coverage for his benefits; this should be permitted.

We believe that the Medicaid program should be federalized and contracted to private insurers for administration. The uneveness of Medicaid benefits and reimbursements can only be leveled through the intervention of the federal government to bring it to a basic plane of comprehensiveness as the national program will provide.

The reimbursement of health providers under a national health program is really our chief concern. We think the variety of circumstances in every conceivable kind of community throughout the land requires local determination and local variation (within limits) of who is paid for what services. Hospitals vary in size, teaching programs, scope of services, and a number of other important ways that require of any national health program the flexibility and variation to meet those differences squarely. What a hospital offers its community in service makes up the financial requirements needed by that institution to fulfill its health service objectives. Any national health program must specifically identify the elements of financial requirements for each health care institution and must assure the institution that any program will meet those requirements. These include but are not limited to provisions for necessary patient care, approved educational programs, approved capital needs, necessary research programs and a sufficient operating margin.

Any payment mechanism must include the total financial requirements and must be met by all purchasers of care. Governmental payment programs, regardless of the payment mechanism, must meet their proportionate share of each participating institution's full financial requirements. In addition any new payment mechanism must, at a minimum, maintain the present levels of reimbursement.

The formulas for the reimbursement of providers under a national health program are, of course, imperative. We are not in favor of retroactive cost reimbursement mechanisms as the sole method of payment. We are equally not in favor of a prospective payment system as the sole mechanism for payment. We do favor those reimbursement formulas that build incentives for a hospital to create new and needed services, innovative delivery of services, and more effective management. We must look to the reimbursement systems that are developed under a national health program to be those that reward providers to their community at costs and in such a way as to provide overall economies. who, without sacrificing quality, are able to provide the total scope of benefits These incentives will stimulate the creative ability of hospitals everywhere to concentrate on those elements that will preserve funds and increase quality. We are confident that such incentives can be included.

In brief, we believe a national health program needs to be financed through a multiple system with the majority of coverage assigned to insurance companies in the private sector. We believe a standard of benefits must be established and that employers and employees purchase that minimum level with each contributing to its cost. We believe the unemployed and underprivileged should have that package of benefits purchased for them by the federal government through one of the approved private carriers. We believe the Medicaid program needs to be brought under that same federal umbrella of benefits and coverage.

PLANNING AND CERTIFICATE-OF-NEED

The AOHA is vitally interested in the implementation of P.L. 93–641, the National Health Planning and Resource Development Act and its relationship to a national health program. Our Association is convinced that a sound and meaningful health planning policy must be founded on a rational planning methodology that does not inhibit or confine innovation and experimentation in the health field.

Sound planning will assure high quality services as well as their availability. accessibility and viability. Planning that meets that objective needs to take into full account the individual's right to seek care from a provider of health services that he chooses as well as the right of that provider to seek to practice in the manner and location of his choice.

The AOHA is clear on the methodology it strongly supports in determining the planning process. This clear-cut methodology includes: (1) Definition of a target population to be served by an institution or given program; (2) Identifying the total health care needs of that defined target population; (3) Identification of the specific needs of the provider institution which would propose to meet that defined population's health care needs; (4) Definition of service programs which would be provided to meet those needs; (5) Identification of the requirements and arrangements to ensure that the services demanded are accessible to the total population.

The AOHA is concerned with the distinct identification of osteopathic facilities and services in the planning process. Osteopathic services should, by their very nature, be categorized separately in the total evaluation of health services with consideration of the distinct services in the osteopathic hospital that are not available from other facilities. Some of these are osteopathic therapy, osteopathic evaluation and other forms of osteopathic practice. These should be recognized as institutional health services unique to the osteopathic field and non-duplicative in other resources.

Closely related to health planning are certificate-of-need laws and regulations that control and regulate the capital expansion of health care facilities. The

AOHA supports the general concept and need for appropriate capital control regulation. We strongly support the basic idea of community-oriented health goals established by providers, consumers and public agencies that will meet and provide for community health needs in a responsible and effective manner.

Although we believe conceptually in certificate-of-need and other health planning mechanisms, our basic concern is that osteopathic facilities be considered separately from allopathic hospitals. Although there may be some maldistribution of hospital beds, the osteopathic bed population and its distribution must be viewed separate and apart from the number and distribution of allopathic hospital beds. When there is not clear separation of allopathic and osteopathic hospital beds in relationship to community needs and population desires, clearly osteopathic hospitals are discriminated against. In many instances, despite the osteopathic hospital's demonstration of a need to increase its bed capacity or additional facilities to meet the legitimate needs of a growing patient population, there is real danger that the osteopathic hospital's proposal will be turned down simply on the basis of the total excess bed capacity within the area. Yet increased community need may well dictate osteopathic institutional growth and/or expansion.

National health insurance should not be seriously debated unless it assures the individual's right to the type of health care he chooses. Implicit in the right to health care for every American is the right to choose from the recognized and properly licensed practitioner the care he, the patient, selects. To deny this right to those millions of Americans who choose osteopathic medicine and osteopathic hospital care would be the denial of what we believe to be an inherent basis for a national health plan, and what has been guaranteed under previous legislation.

Three states—Florida, Rhode Island and Oklahoma—have come to grips with this problem and have established separate certificate-of-need consideration for osteopathic hospitals. We strongly urge this subcommittee to consider this issue in its many deliberations relative to a national health program. AOHA will do everything possible to further this important cause.

THE MALPRACTICE CRISIS

The AOHA has actively participated in the study groups, conferences, hearings and other actions on the malpractice insurance problems facing the health industry. The problems of adequate coverage of this type of insurance are multifaceted and are understood by this Committee.

Our member hospitals have been struck as dramatically as other health care facilities with the staggering increases in the cost of malpractice insurance. We have evidence of a 249 percent increase in premiums of one of our members; a 400 percent increase of another; and a 300 percent increase of still another. Because of the nature of hospital income and expenses, these and other increases in the cost of doing business have naturally been allocated to increasing amounts due from patients. There is really no other source for hospital incomes other than from service to patients.

We believe the solution to the malpractice insurance problems will be realized through a two-fold approach. The first short term solution must assure the availability of liability insurance at costs that are realistic. The federal government has played and can continue to play an important role in this arena.

The long-range solution lies, in our opinion, at the state level with a significant amount of help, information and encouragement from the private sector. More states have to be willing to experiment in local answers, and we encourage the Congress to provide the initiative as well as the guidance to state legislatures, and providers, and the insurance carriers to evaluate and undertake experiments in such programs locally. Joint underwriting, limitations on recoveries, limitations on contingency fees, broader use of collateral sources, various forms of arbitration, and other formulas need experimentation to prove their effectiveness and require risks that only the federal government can underwrite.

The no-fault insurance approach has been widely rejected in the malpractice field. As an association we rejected it early as a possible solution to the problem. We felt then, as we do now, that the no-fault concept would be ineffective.

We emphasize that the federal role in the solution to the malpractice problem is not a dominant one. The direction and incentives necessary to the states can come from the Congress and executive branch of the government. In its relationship to a national health insurance plan, great strides toward solving the problem financially and in an effective manner can come from attention to the problem in the NHI proposal. National incentives to state legislatures can be established in the area of malpractice solutions through a national health law, and certainly the malpractice coverage problem can be approached through the federal payment of patient costs for care. No national approach to health coverage can or should ignore this ever-present malpractice cloud that has hovered over the health industry for much too long a time.

We include discussion of this issue in our presentation on a national health program for two reasons: First, we believe it is essential that this subcommittee be fully aware of how dramatically this particular issue impacts hospitals and the rising cost of health care.

Second, and more germane to a national health program, is our hope that such a plan will be flexible enough to allow providers and the industry at large to respond in appropriate and effective ways when, in the future, problems of this magnitude might arise again. The system should be flexible and should assure providers full and appropriate reimbursement for such increased operating costs which are beyond the hospital's control. The problem should be carefully developed and include an ongoing planning and forecasting mechanism to foresee, where possible, such problems before they reach catastrophic proportions.

ROLE OF GOVERNMENT

In several places in this statement we have made references to the role government (federal and state) might play in the development and implementation of a national health program. It should be clearly stated that the AOHA believes there should be as little government regulation as possible, and that which is necessary should be in the form of broad standards to allow state and local governments the greatest degree of flexibility.

The health care industry is subject to a myriad of fragmented controls and programs at all levels of government—federal, state, and local. Hospitals are faced with this plethora of regulatory agencies and programs and only on rare occasions are these regulatory elements effectively coordinated. A national health program must provide an opportunity for the nation to make some sense from this multitude of overlapping efforts. Consideration should be given to establishing a balanced process in which the federal government would act as a catalyst and monitor to achieve the necessary changes in our national health policies to assure the implementation and realization of the goals of a national health program. The role of government in such a program should be to provide general, overall direction, support, and incentive, as well as technical expertise upon request to implement a national health program at the local level. The federal government should establish broad national standards and guidelines to be adhered to at the local level to assure some degree of uniformity throughout the nation.

The osteopathic hospitals, as community hospitals serving the health care needs of millions of Americans throughout this country, are concerned with the multiplicity of federal agencies and departments which issue regulations directly impacting on the operations of our hospitals. We share a similar view with other health care groups that view the system of federal rule-making as largely uncoordinated and often arbitrary—oftentimes creating substantial costs and administrative burdens which can have deleterious effect on the capacity of health care institutions to provide quality health care to citizens.

The American Osteopathic Hospital Association strongly believes that a formal mechanism for Congressional review of administrative rule-making is necessary and an overdue reform of current procedures. We view this as only one step of many which must be taken to bring about a more rational, logical, economical process by which administrative rule-making more appropriately implements the laws enacted by Congress.

MANPOWER RESOURCES

Any national health program must assure the necessary manpower resources to adequately provide the health care benefits promised to the American people. The present health care delivery system, including its current complement of personnel, is probably not capable of delivering comprehensive health care benefits to the entire U.S. population.

While most national health insurance proposals already introduced in the Congress address the general issue of reorganization of the delivery system, most do not address the question of assuring an adequate number of properly trained health care personnel to deliver that care.

Increased unionization of hospital and health care employees; increased and more sophisticated medical technology requiring specially trained personnel; increased numbers of job functions in health care institutions; increased wage rates and fringe benefit programs for health care employees; as well as an increased number of governmental rules and regulations affecting the employment and/or discharge of employees—are all factors which make the entire issue of manpower resources crucial in any consideration of a national health program.

Manpower resources account for one of the largest single elements of cost in health care expenditures. To ignore this issue—which is complex and which relates to every other issue involved in the consideration of a national health program—would not be in the best interest of the American people.

SUMMARY

In summary the American Osteopathic Hospital Association favors the following:

1. Major problems facing the health care field such as planning, certificate-of-need, malpractice and reimbursement can be alleviated through a national health program.
2. We are in favor of a national health program with comprehensive health care benefits available to all Americans.
3. We urge reimbursement formulas that have built-in incentives for each provider that will encourage efficiencies and innovative programs, and which will provide for continued growth to meet expanding health care needs.
4. We favor a mandated insurance program purchased through the private sector by both employer and employee.
5. We stand firm on the principle of free choice whereby individuals may select the provider of choice.

Finally, we urge that the national health program be designed utilizing the many strengths that now exist in our health care system. A good example of these strengths is the Board of Trustee system that links the community served to the institution. Thustees are an invaluable part of our health care today and should be preserved as imperatives in the future.

This statement has attempted to identify the major concerns of this Association relative to a very complex set of issues. Once again we call your attention to our appended statement which addresses additional issues.

The American Osteopathic Hospital Association views a national health program as a master plan for health in this nation; one that guarantees health care to a population that has demonstrated its interest and desire for excellency in health services, and quality through that excellence.

POSITION PAPER ON A NATIONAL HEALTH PROGRAM

(Approved by Board of Trustees, April 5, 1975)

INTRODUCTION

Many leaders in Congress have indicated that the 94th session of the Congress will include consideration of and likely passage of a national health insurance program.

The American Osteopathic Hospital Association (AOHA) has not, in the past, identified support for a particular national health insurance proposal. The AOHA, rather, has stated its position on the important issues to be considered in any such program. The purpose of this position paper is to restate and more clearly identify the position of the Association on the major issues included in any national health program. This position paper is based on established AOHA policy.

The American Osteopathic Hospital Association is the national association of osteopathic hospitals—there are 210 osteopathic hospitals in 27 states. These hospitals account for more than 25,000 inpatient beds and will spend in excess of $700 million this year. The delivery of primary health care is the major role and objective of osteopathic physicians and their hospitals. By virtue of their education and philosophy osteopathic physicians, for the most part, are general practitioners or specialize in primary care and deliver health care to millions of Americans.

It has been estimated that osteopathic physicians and their hospitals, which represent less than 5 percent of the total number of physicians and less than 4 percent of the community hospitals in the country deliver primary health care to 10 percent of the population. In addition many osteopathic hospitals are the only hospital in the geographic region they serve.

The question has been asked of this Association why it is developing a position statement on this issue. The American Osteopathic Hospital Association does not believe its views and the views of its member hospitals representing the very important issues involved in the debate on a national health program have been adequately represented, in their totality, by any other organization or by any single piece of legislation. Therefore it is the purpose of this paper to present the position of this Association on the key issues involved.

NATIONAL HEALTH PROGRAM

The American Osteopathic Hospital Association believes it important and in the best interest of the people and the providers that a national health program which would provide universal coverage, accessibility and availability of comprehensive health care benefits for all Americans be enacted by Congress. This program should not be a governmental program but should be financed through a multiplicity of sources, including funds from the private sector. We distinguish a national health program from a national health insurance program in that the latter is a federal government program which our Association does not believe would meet the health needs of the people of this country.

The federal government's role should be that of a catalyst and supporter. Government, however, should not be directly involved in the delivery of health care. Nor should government be the primary or only source of financing such a program. By establishing a national health insurance program government would assume a primary role and would deny the private sector the role it is capable and appropriate to play. Furthermore a national health insurance program would ignore that which has been accomplished to date and we do not believe a federally financed, federally administered, federally controlled health system would work in this country founded on the free enterprise system.

GOALS

Any national health program should be based on a specific set of goals to include:

1. Universal coverage of all Americans.
2. Availability, accessibility, and affordability of comprehensive health care by all Americans.
3. Comprehensive health care benefits should include: preventive, health maintenance and ambulatory care, inpatient care at all levels of patient care, mental health, as well as catastrophic health benefits.

Finally any national health program should include a minimum amount of regulatory provisions to allow the private sector, in open-market spirit, to develop the kinds of programs and delivery systems to most adequately meet the needs of Americans as promised under such a program. Specifically, such a national health program should include separate consideration for osteopathic facilities and institutions in any planning or certificate-of-need process. Osteopathic hospitals and their physicians play a unique role and serve a major population base in this country. Osteopathic medicine is a separate school of medicine with a different philosophy of health care than that of M.D.'s. Osteopathic medicine as a separate school has different training requirements, different hospital accrediting procedures and a different and unique emphasis on treating disease. Individual practitioners and all patients should be guaranteed their freedom of choice already established in law by preserving the basic tenets of our present system.

HEALTH CARE BENEFITS

The concept of freedom of choice for both the individual patient and physician are important basic freedoms to be maintained in any national health program. This must include the freedom for the individual to select the provider of his choice and freedom for the provider to practice in a manner and in a location of his choice. No national health program should mandate or in any way force any individual to seek health care from a provider other than the provider of his choice. At the same time no national health program or policy should force a provider of health care to practice his profession in any way other than that selected by the individual.

Mandated health care benefits under a national health program should include a full scope of comprehensive health care benefits—including catastrophic benefits as well as preventive health maintenance and ambulatory care, inpatient care, medical service benefits and mental health benefits.

A national health program should move toward the elimination of any distinction between benefits for physical and mental illness. Acute mental illness benefits are insurable at a reasonable cost and there are many sound arguments for coverage equal to that provided for other kinds of illness.

This Association fully recognizes that the present health delivery system may not be fully capable of providing totally comprehensive health care benefits to all Americans by the mere signing of legislation into law. This Association does believe, however, that the federal government has a responsibility to provide incentives and support for the health delivery system to be able to enable it to provide the total scope of comprehensive health care benefits to all Americans.

Therefore, it is the position of the American Osteopathic Hospital Association that a total range of comprehensive health care benefits (i.e. preventive. health maintenance and ambulatory care, inpatient care at all levels. catastrophic care and mental health benefits) should be included in a national health care program. Steps must be taken immediately to assure the ability of the delivery and financing systems to provide such benefits to all Americans within a reasonable length of time.

FINANCING

There are many issues surrounding the financial aspects of a national health program. The source of funds to finance a national health program is one of these key issues. To achieve the dual objective of equity and effectiveness the AOHA strongly believes multiple sources of fiancing must be utilized. including general federal tax revenues, Social Security taxes, and mandated premium payments by employers through the private sector. In addition, the Association believes in the basic principles that every person who is able to do so should contribute to the cost of his own health care, as long as it does not create a barrier to the person seeking health care.

The American Osteopathic Hospital Association is categorically and unequivocably opposed to the trust fund approach for financing health care. There are many weaknesses and disadvantages to such an approach, including the following: It would center administration of the national health program in one agency, thereby creating inflexibility in seeking new and innovative ways to finance new benefits or provide for more efficient administrative systems. It would ignore an experienced and valuable resources presently existing in private health insurance industry. It would require an accurate assessment of the utilization of health care services by the entire population and establishing a single tax basis to finance such benefits. It would create inequities in the relationship between the amount of the tax which would be the premium and the number of beneficiaries covered. Finally, it is not the single or even the most effective way to assure that all people have access to the same level of benefits.

The mechanism to provide reimbursement to health care providers relates to two issues. The first of these is the financial requirements upon which any reimbursement is based and the second is the mechanism for reimbursement.

Because health care institutions serve every conceivable kind of community and because of the differences in size, type and scope of services they provide—hospitals' financial requirements as well as their ability to underwrite services for non-paying patients can vary to a considerable degree. Collections from self-paying patients and payments from third party payers must yield sufficient receipts to meet the total financial requirements of each health care institution. These financial requirements are the monetary resources needed by each health care institution to fulfill its community health service objectives. Any national health program must specifically identify the elements of financial requirements for each health care institution in detail, and it must assure meeting those through the various payment mechanisms.

The American Osteopathic Hospital Association is opposed to the continuation of a retroactive cost reimbursement mechanism as the only reimbursement mechanism. This reimbursement mechanism does not always take into account the providers' full financial requirements, and offers little or no incentive for innovative programs.

Any national health program and its financial and regulatory provisions should maintain the highest degree of flexibility to allow for experimentation in the development of innovative programs. In addition the greatest amount of discretion should be maintained for state and local areas to determine the reimbursement mechanism, the delivery pattern, and the manner in which it will meet the goals established by any national health program. Incentives should be built into the reimbursement mechanism to reward those providers who, without sacrificing quality, are able to provide the total scope of benefits to its community at costs and in such a way as to provide overall economies. The national health program should set broad guidelines establishing a minimum level of comprehensive benefits and a financing mechanism to assure freedom of choice by the individual, as well as incentives to encourage innovation in financial reimbursement mechanisms and new delivery systems.

DELIVERY SYSTEM

It is the opinion of the American Osteopathic Hospital Association that the enactment of a national health program as called for in this statement does not require the total reorganization of the health delivery system. Alternative delivery systems and changes in the structure must evolve over time based on community health needs, local initiative and the experience gained under a new national health program which provides comprehensive health benefits. The continued existence of osteopathic institutions must be assured.

Experiments and the development of new delivery patterns over the last several years have adequately shown that one delivery mechanism is not applicable to all communities in this country. This Association applauds the attempts undertaken by the federal government and the private sector in developing health maintenance organizations, experimental health delivery systems, and other health delivery mechanisms. And we acknowledge that in some communities and for some population groups these mechanisms have worked and worked well. These mechanisms, however, have not proven to be a panacea for every community, and therefore should not be imposed upon the local community.

The question of the organization of the delivery system is a question which must be left to each locality. A new delivery system must not be superimposed on local providers and communities. Rather new delivery systems must evolve at the local level and be developed based upon the objectives and standards established by a national health program.

A national health program must, however, provide incentives, support and technical assistance to all communities in their efforts to evolve and develop an appropriate and adequate delivery system. Any such national health program must include incentives to assure the primary goal of quality and comprehensiveness of benefits as well as the availability and accessibility of those benefits for all people, with a free choice of providers.

Access to quality care and availability of that care will be important goals to keep in mind when broad scale benefits and financial support for them are extended by a national health program to the entire population. While it is critical to develop a benefit package that is as comprehensive as possible for the total population, there should also be assurances that the actual facilities and services to provide these benefits will be available and accessible. Given the appropriate resources and support, the private sector can and will meet the nation's health care needs.

In developing legislation for national health program, consideration should be given to the establishment of a health resources development fund which would be financed from money collected to pay for health care benefits or from some other appropriate source. Such a health resources development could provide funds for communications, transportation, scientific and administrative systems and facilities needed for a national health program. We believe such support will be particularly necessary in the development of outpatient and ambulatory care service programs.

ROLE OF GOVERNMENT

The health care industry is subject to a myriad of fragmented controls and programs at all levels of government—federal, state, and local. Hospitals are faced with this plethora of regulatory agencies and programs and only on rare occasions are these regulatory elements effectively coordinated. A national health program must provide an opportunity for the nation to make some sense from this multitude of overlapping efforts. Consideration should be given to establishing a balanced process in which the federal government would act as a catalyst and monitor to achieve the necessary changes in our national health policies to assure the implementation and realization of the goals of a national health program. The role of government in such a program should be to provide general, overall direction, support, and incentive, as well as technical expertise upon request, to implement a national health program at the local level. The federal government should establish broad national standards and guidelines to be adhered to at the local level, to assure some degree of uniformity throughout the nation. It is the position of the American Osteopathic Hospital Association that there should be as little government regulation as possible, and that that which is necessary should be broadly established standards centered at the state and local level in order to maintain the greatest degree of flexibility and responsiveness to local community needs.

As mentioned previously, the AOHA believes another major role for the government in the national health program is to encourage experimentation in new financing and delivery system alternatives as developed and recommended by providers and their communities.

The federal government should also finance benefits for the aged and the socially and economically disadvantaged through a single program. The present Title XIX Medicaid system has proven ineffective and has resulted in inequities among the states. The federal government must assume the responsibility for this segment of the population.

It is the position of this Association that osteopathic facilities must be singled out for separate consideration under state certificate-of-need laws. There seems ample evidence in Florida and Rhode Island, where this has already taken place, for the justification and need for the separate consideration of osteopathic facilities and services under each state certificate-of-need law.

It is absolutely essential that all provider groups be adequately and appropriately represented on advisory councils and committees involved in the decision-making process under a national health program. Specifically osteopathic institutions and osteopathic physicians must be represented on such bodies.

The AOHA believes there should be a separation of the planning and regulatory functions in any national health program. To some degree both issues need to be fully addressed in the debate surrounding a national health program. And to a lesser degree it seems inevitable that some planning and regulatory programs will be included in a national health program. These two processes should be maintained as separate processes because planning activities become undermined when regulatory functions are molded into the same process.

MALPRACTICE/GENERAL LIABILITY INSURANCE

A national health program enacted in the mid-1970's cannot ignore one of the most serious crises facing the health care industry at this time—the medical malpractice insurance crisis. Physicians and hospitals are finding it increasingly difficult, if not impossible, to obtain appropriate insurance protection at a reasonable cost. In some instances, they are unable to find any insurance protection at any cost. This is neither the time nor the appropriate vehicle to explore the reasons and the potential solutions to this very grave crisis. It is important here, however, and in the debate surrounding a national health program and in the legislation enacted to implement a national heatlh program that consideration be given and remedies be provided for this important issue.

IMPLEMENTATION PROCESS

The present health care system constitutes a firm foundation for the implementation of a national health program. A redirection of the resources presently employed in the health care system would go a long way toward meeting the goals and objectives of a national health program as outlined in this paper. It is unreasonable to expect, however, that a program of this magnitude could become fully operational and effective upon the immediate enactment of legislation. Manpower resources need to be developed and adequate provisions made to assure the appropriate supply of manpower. Institutional as well as professional providers will need to rethink their role and the manner in which they participate in the total delivery program. Financing mechanisms will have to be implemented and reimbursement programs determined. It is absolutely necessary, therefore, that a national health program be implemented over a period of time with available financial, organizational and professional resources. Any enacted national health program should include a planned but definite implementation process. As adequate resources are developed and organized, benefits could be expanded progressively both in scope and in application to various professional groups.

CONCLUSION

The American Osteopathic Hospital Association and its member hospitals believe the position taken by them in regard to a national health program is reasonable and responsible. It is important that hospital representatives—chief executive officers, members of the governing body, and members of the medical staffs—discuss with their representatives in Congress the viewpoints of the hospital on the important issues surrounding national health insurance. This Association will make its position known to the Administration, Congress and appropriate agencies and organizations in the most effective means. This Association stands ready and willing to assist and provide expertise available when called upon.

STATEMENT OF NATIONAL RETAIL MERCHANTS ASSOCIATION

The National Retail Merchants Association ("NRMA"), a non-profit corporation, represents approximately 30,000 department, chain and specialty stores in the United States, Canada and almost 50 other foreign countries, many of which are operated by small retailers. The aggregate annual sales volume of our members exceeds $80 billion.

OUTLINE OF NRMA STATEMENT

A. Introduction.
    1. Retailing industry is unique.
B. The NRMA Position.
    1. Rising costs of health care.
    2. Responsibility of federal government.
        a. Facilities planning.
        b. Intensive program for training medical and dental "para" personnel.
        c. Detailed and universal accounting standards as well as incentive cost controls.
        d. Broad-based atack on major illnesses. (1) Staffed by paramedical training program.
    3. National Major Illness Program.
        a. Protection against major illness expenditures.
        b. Phased in approach with respect to benefits.
        c. Private administration.
        d. Sharing of premium costs between employer and employee.
        e. Benefit value equivalence.
        f. Cost controls.
        g. Opting out by secondary waeg earners and "moonlighters".
        h. Coverage only with respect to regularly scheduled employees.
        i. Unique problems of small employers.
        j. Federal preemption.

INTRODUCTION

The retailing industry is labor intensive, employing a large percentage of the nation's labor force and operating on a profit margin which is quite low in comparison to most other industries. The recent NRMA Industry-Wide Study Reviewing the Relationship Between Health Care Benefits Afforded and the Efforts to Legislate National Health Insurance ("NRMA Study") found that the retailing industry has a disproportionate number of part-time and seasonal employees as compared with other industries. Moreover, a large percentage of the persons employed in the retailing industry are secondary wage earners whose participation in group medical insurance programs involves significant duplication of coverage and costs.

The retailing industry is very sensitive to changes in the economy, in consumer buying habits and in prices. This is due in large part to the fact that retailing is highly competitive, with many apparently dissimilar businesses operating in proximity. Thus, any legislation which is universal in application may have an extremely adverse impact on the retailing industry and, ultimately, the nation, if such legislation ignores the unique characteristics of industries such as ours.

THE NRMA POSITION

1. Health and medical care expenditures in the United States have increased almost tenfold during the last quarter of a century. During the same period, the average health bill for each American has increased more than 450 percent.

Hospital care, the largest single item in the nation's health care bill, increased more than 10 percent during the period fiscal 1972–fiscal 1973—at a time when these costs were controlled by the Cost of Living Council.

The spiralling costs of health care in the United States represent a major economic problem which is not susceptible of easy solution. Caution must be exercised in attempting to fashion a cure. Any total cradle-to-grave program of national health insurance, when superimposed upon our present health delivery system, may serve to aggravate the situation. The resulting increase in the demand for services, without a corresponding increase in the supply, may worsen the current problem.

2. A major responsibility of the federal government in the health care field should be to control medical and hospital inflation, which has been placing more and more services out of the reach of the American people and which has been seriously straining the health delivery system.

To this end, the federal government should (a) engage in facilities planning on a national scale, making available appropriate loan and advisory facilities; (b) engage in an intensive ten year program of training medical and dental "para" personnel, through grants, scholarships, etc., in order to ensure an increase in supply to meet the increased demand, while fighting inflation and increasing the availability of professional medical and dental care throughout the country; and (c) establish more detailed and universal accounting standards for hospitals, as well as incentive cost control methods.

In addition, the government should sponsor a broad-based attack on such major illnesses as cancer, heart and circulatory disease, alcoholism, drug addition, and mental and nervous disorders. A nationwide pubic health program (including pollution control and a mass educational program in connection with immunizations, diet, child and pregnancy care, and diagnostic care for children) should also be developed. This public health program should be staffed in large part by a two or three year "Medical Vista" commitment by the people in the paramedical training program described above.

3. A National Major Illness Program should be implemented as a minimum standard of reimbursement to protect individuals and families from financial hardship caused by medical expenses.

Part I of the National Major Illness Program should cover the aged and the unemployed. With respect to those groups, the plan should be financed by the federal government out of general revenues and should be administered by the private sector of our economy.

Part II of the National Major Illness Program should cover the other segments of our society as follows:

A. The plan should cover significant medical expenditures (for example, hospital and surgical care, x-rays and laboratory fees) in excess of a uniform, specified dollar level, designed to prevent severe economic hardship to the employee and his family. Expenditures for services such as dental, visual, hearing, nursing home, out-of-hospital psychiatric, long-term in-hospital psychiatric, prenatal and well-baby care, or payments for prescription drugs, should not be included within those covered. To go further, without substantially improving the health delivery system, may increase our health care problems.

B. The plan should provide for a phasing-in of the benefits covered pursuant to paragraph A above.

C. Any plan that is legislated should be administered by the private, rather than the public, sector of our economy. The millions of American working in the insurance field represent a vast fund of expertise and administrative capability that should be utilized. Governmental administration would be unworkable. Supervision of Medicare has stretched the federal government's administrative capacity near its limit, creating numerous problems which remain unresolved. A federally-administratered program would pose administrative burdens that far exceed those of Medicare.

D. Employers and employees initially should not be required to pay more than 50 percent of the premium costs of any national health insurance plan (without any salary limitation for the employee). However, employers who currently pay more than 50 percent may retain their current cost arrangements.

E. The concept of benefit value equivalence should be included in the plan. If that concept is included, employers having plans which are at least equivalent to the national plan would not be required to alter such plans in order to meet the particular nuances of any national plan.

F. Cost controls must be included in any national plan. The concept of cost control encompasses deductibles, coinsurance provisions, and peer and utilization review systems, including the use of budgets and a uniform procedure for dealing with malpractice liability claims.

G. The secondary wage earner in a family should be permitted to opt out of a particular employer's plan if the primary wage earner is a full-time employee covered by another employer's plan. In addition, an employee holding jobs with two different employers should be permitted to opt out of one employer's plan if he so desires. In either case, if the employee chooses to opt out of an employer's plan, that employer's contributions (as well as those of the employee with respect to such employment) should not be required. In no event should there be a duplication of claims payments.

H. Coverage should be required only with respect to regularly scheduled employes (those employees who work a minimum of 20 hours per week for a period of six consecutive months). Since retailing has such a disproportionate number of part-time and seasonal employees, the addition of a significant financial obligation to provide health insurance benefits for such employees would impose an extraordinary burden on thousands of retailers.

I. The NRMA Study indicates that most, if not all, of the retail stores that currently have no plans at all are relatively small retailers. In order for a national health insurance package to be financially feasible to a small employer (e.g., one whose health plan would cover less than 100 employees), special measures are required. Thus, economies of mass purchasing should be made available through the use of private insurance pools. In addition, the national plan should provide for partial subsidization of these small employers by the federal government (out of general revenues) which would be phased out over the early years of the plan. During this period of partial subsidization, the premium costs should be shared equally by the employer, the employee and the federal government.

J. The federal health insurance plan should preempt any state health insurance plans. The failure to so expressly provide in the national plan will result in the chaotic situation which the federal plan was designed in large part to avoid.

CONCLUSION

Absent some major improvements in our present health delivery system, national health insurance may create more problems than it will solve. We have outlined a number of proposals which should serve to minimize those problems.

We would like to thank the Subcommittee for permitting us this opportunity to present our views on the question of national health care legislation. We are greatly concerned over this most vital issue—both as citizens of this country and as members of an industry that is uniquely sensitive to this problem. Representatives of the NRMA would be pleased to assist the Subcommittee and its Staff in any manner that the Subcommittee deems appropriate.

Statement of the American Retail Federation

The American Retail Federation welcomes this opportunity to present its views at this time on the important issue of national health insurance.

After more than three years of in-depth study, discussion and debate, conducted by the Federation through industry experts and affiliates in all 50 states and the District of Columbia and 30 national retail associations, a statement of principles on national health insurance was approved by ARF's Executive Committee in September 1975. This policy is set forth as follows:

"Any national health insurance legislation must recognize that cost of coverage will be a major factor for many employers, particularly labor-intensive industries such as retailing, where a high percentage of costs goes to payroll. Also, many retail employers, particulary smaller could include: Phase-in of benefits; phase-in according to the size of the business establishment; or phase-in of the employer's share of premium."

As stated above, these are principles which retailing believes should be embodied in any comprehensive national health insurance legislation; they should not be construed as indicating support or opposition of any particluar bill.

We look forward to the opportunity of our experts' discussing these principles in detail with you or your staff so that, where and when appropriate, they will be embodied in whatever legislation your Subcommittee may adopt.

In the meantime, you may wish to refer to the statement of the National Retail Merchants Association submitted to the Subcommittee on April 15, 1975, which the Federation fully supports as a more detailed expression of the principles set forth above.

Thank you for the opportunity to contribute our constructive views with respect to this crucial issue.

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION

In July, 1975, the 10,000-delegate Representatives Assembly of the National Education Association reaffirmed the demand of the nation's teachers for a truly comprehensive federal Health Security program. The policy statement, adopted as a major priority for action by the 94th Congress, is as follows:

"The NEA supports federal legislation to provide comprehensive coverage of hospitalization charges, physicians' services and fees, and prescription drug expenses to all persons, regardless of age or income, who are citizens or residents of the United States."

The NEA's interest in national health insurance, now specifically focused on a universal bill, actually goes back many years—to the time when Congress and the nation began seriously studying whether the federal government should provide some assistance to large segments of the population who were unable to afford basic health care. NEA supported the Medicare and Medicaid programs enacted ten years ago to help the aged and the poor gain access to health services.

But during the ten years since Medicare and Medicaid began, little or nothing has been done legislatively to solve other problems in the health care field: alarming increases in medical costs, maldistribution of health care resources, and no enforceable standards of quality in medical service. These problems have been compounded for the poor and the elderly, who must pay more and more in deductibles and coinsurance for health coverage. And the health insurance industry has been unable or unwilling to help those who cannot pay premiums or who are considered "high risks" (women, generally, and anyone with a history of serious illness).

The best available statistics show that this nation is on the brink of a health care catastrophe. The average American spends one month's pay per year for medical services—considerably more than the cost to the average citizen of any other industrialized society. Since the lifting of price controls in April, 1974, health cost inflation has accelerated at an annual rate of 18 percent, far exceeding that of general inflation. America ranks 17th among developed countries in deaths of infants during the first year, 27th among countries of the world in life expectancy of males and 12th among females. About 40 million Americans have no hospital insurance at all, and millions of additional working people and their families do not have the security of knowing that their hospital and medical costs will be paid during layoffs and periods of unemployment. Teachers are no better off than other citizens in terms of employment-related health insurance. As recently as 1972/73, 16 percent of teachers in districts enrolling 6,000 or more had no hospital or medical insurance benefits in their contracts, and less than half had hospital and medical insurance paid for in full by their employers.

Beyond the obvious cost in human suffering and anxiety, these statistics point to increased welfare costs and further economic erosion in our society. We cannot afford to drift further. We must face the fact that America has not viewed quality health care as a basic right. Until this right is guaranteed, other recognized rights—such as the right to speak, to associate freely, to learn, to work, or to vote—are utterly meaningless. People who are too sick to do these things are deprived of rights otherwise guaranteed by law.

To establish health care as a right, NEA believes the Congress should enact the broadest possible legislation to counter the major problems in this area. NEA favors the approach taken in HR 21, the Health Security Act introduced by Rep. Corman and 100 cosponsors. Its counterpart in the Senate is S 3, introduced by Sen. Kennedy and 20 cosponsors.

NEA recognizes that the fundamental changes in delivery of health care envisioned by the Kennedy/Corman bill are controversial. Such vested interests as the health insurance industry, the providers of health care (individual, corporate, and institutional), and the builders and suppliers of equipment and facilities feel threatened by what they perceive as a federal "takeover" of the health care system.

The problem is that the United States does not have a health care system, and the fact is that the Kennedy/Corman bill does not propose nationalization of anything connected with health care. It does, however, propose basic changes in the way money is spent on health maintenance and care. The money it proposes to redirect is already being spent: $100 billion or more per year.

This Committee knows that American health care is paid for by a fragmented, uncoordinated nonsystem—by individual consumers, by health insurance companies, by Medicare, Medicaid, and other federal and state programs. Accountability gets lost in a nonsystem, and the consumer is the ultimate loser. The consumer is in double jeopardy—paying heavily for minimal health insurance benefits and taxed to pay for government-supported programs whose value is constantly eroded by inflation.

Proposals that fail to create order out of the present chaotic state of health care can only exacerbate the problem. Patchwork, add-on legislation such as mandated employer/employee plans and the so-called "catastrophic" bills would simply delay vital and constructive reform.

As others have pointed out, the Health Security bill would scrap existing federal programs that provide entitlement based on income. This is the first and greatest principle of Health Security. Gone forever would be the needs tests, the deductibles, and the coinsurance requirements that reduce the individual consumer to the demeaning level of a beggar. Gone, too, would be the billions of pieces of paper that are shuffled around in the claims processing procedure.

The NEA and other advocates of Health Security recognize that manpower resources would have to be in place before basic reforms could be implemented. The Kennedy/Corman bill provides for the development and redeployment of resources before government even begins to pay benefits. The redeployment of manpower, it should be noted, would be encouraged by financial incentives—not mandated by a bureaucracy.

Health Security would depress rather than inflate costs. The built-in system of advance budgeting, arrived at with the full participation of consumers and providers, would protect all interests and encourage greater efficiency in the delivery of health care. The insurance companies would not go broke if Health Security were passed, and the creation of a viable system would require the skills and talents of those now employed by the health sector of that industry.

We find in the opposition to this legislation three basic arguments. The first has to do with costs. We have pointed out that the bill redirects the way the nation pays its medical bills. The money is the same. The manner in which it is collected and disbursed is changed, in ways that benefit consumers and providers alike. The second argument is that government is incapable of administering a Health Security system. We find this argument absurd; a well-drawn law can be administered justly and efficiently, and many federal programs have succeeded beyond all expectations. The third argument is almost never voiced openly. It is that the federal government should not spend money on people "who aren't making it on their own." This argument simply flies in the face of justice, decency, and humaneness, and we should watch for the disguises it takes in public forums.

In summary, we urge this Committee's favorable consideration of the Health Security bill. It is no panacea, but its basic concepts are eminently sensible. It is a social insurance bill, but it is not a socialized medicine proposal. Government intervention for the common good is a respected American tradition; government ownership of industry is not. We do not support the format of European national health systems, and the Health Security bill avoids the pitfalls of those systems. Rather, it builds on the experience and excellence that we have and does away with everything that stifles rights and restricts opportunity for all.

[Whereupon, at 6:15 p.m. the committee adjourned.]

APPENDIX

94TH CONGRESS
1ST SESSION

H. R. 1

IN THE HOUSE OF REPRESENTATIVES

JANUARY 14, 1975

Mr. ULLMAN introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To establish a new program of comprehensive health care benefits (including catastrophic coverage) and health care delivery to be available to all residents of the United States, financed by payroll deductions, employer contributions, and tax credits, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, divided into titles, parts, and sections in accordance with the following table of contents, may be cited as the "National Health Care Services Reorganization and Financing Act".

VI—O

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Sec. 2. Findings and declaration of purpose.
Sec. 3. Definitions.

TITLE I—FINANCING OF NATIONAL HEALTH SERVICES

Sec. 100. Short title.

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FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) Recognizing that health care is an inherent right of each individual and of all the people of the United States, and that in fulfilling this right each individual shares the responsibility for protecting his or her own health and for obtaining health care when required, the Congress finds and declares that health services must be so organized and financed as to make them readily available to all, without regard to race, creed, color, sex, or age, and without regard to any person's ability to pay; that the services must be so provided as to enhance the dignity of the individual and promote better life for all; and that it is a function of Government to assure that these ends are attained.

(b) The Congress finds that the functions of the Federal Government, exercised primarily through a new Department of Health established to deal exclusively with health and related matters, should include financial assistance to members of the public in obtaining health care services in accordance with the principles—

(1) that the Federal Government should require all employers to contribute to the purchase of Comprehensive Health Care Benefits for their employees;

(2) that the Federal Government should assume the cost of purchasing or subsidizing, through tax credits

and deductions and in other ways, health insurance for those unable to pay for it, or unable to pay in full;

(3) that social insurance should continue to finance hospital care for the aged; and

(4) that to encourage participation by individuals in new health delivery and benefit programs, the Federal Government should provide a financial incentive.

(c) The Congress further finds that achievement of these purposes requires substantial modification of the organization and methods of delivery of health services and the methods of financing them, and that these purposes will best be served by the creation of a nationwide system of independent Health Care Corporations embodying the principles—

(1) that each corporation should combine, either in its own structure or by affiliation, institutions and professionals qualified to furnish the entire range of health services, and should provide to its registrants an integrated and comprehensive program of health services, emphasizing preventive and outpatient care and embracing health maintenance services, primary care, specialty care, rehabilitative care, and palliative and terminal care;

(2) that such independent corporations should span the Nation, so that every resident of the country will

have the opportunity to register with a corporation and, where practicable, a choice among corporations; and

(3) that such corporations should be locally established and operated, but should be subject to State regulation through State Health Commissions and to national standards of quality and scope of services.

The Congress finds that, with assistance from the Federal Government to members of the public and also in the development of Health Care Corporations and the creation of needed outpatient facilities and home health care programs, such a system of health care delivery and comprehensive benefits can become operative nationwide within five years after the enactment of this Act.

(d) Pursuant to the foregoing findings, and to carry out the foregoing declarations, the Congress by the enactment of this Act declares and provides—

(1) that all persons residing in the United States will be eligible to participate in the program created by this Act, beginning in the fifth year after its enactment;

(2) that each person so participating will be entitled to receive from a Health Care Corporation services as described in this Act, if he has registered with the corporation and has obtained a qualified health benefit coverage from a carrier, or on the basis of his income or his age has been provided with such a coverage;

(3) that such coverage will be provided without cost to persons in the lowest income bracket and at reduced cost to persons in the other income brackets specified in this Act; and

(4) that such coverage will be provided through payroll taxes and general revenues to persons who have attained the age of 65.

(e) It is the intent of the Congress that appropriate philanthropic support for health care be continued and expanded under the program created by this Act, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services. Nothing in this Act, therefore, is intended nor may be construed to eliminate or limit philanthropic support or incentives for such support for Health Care Corporations and health care institutions.

DEFINITIONS

SEC. 3. For the purposes of this Act—

(1) the term "Commonwealth Health Care Benefits" means the benefits described in part B of title I;

(2) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(3) the term "United States", when used in a geographical sense, means the fifty States, the District

of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(4) the term "Governor" includes the Mayor of the District of Columbia; and

(5) the term "Secretary" means the Secretary of Health.

TITLE I—FINANCING OF NATIONAL HEALTH SERVICES

SHORT TITLE

SEC. 100. This title may be cited as the "National Health Care Services Financing Act".

PART A—EMPLOYER REQUIREMENTS AND ENTITLEMENT TO BENEFITS

REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR EMPLOYEES

SEC. 101. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR EMPLOYEES

"SEC. 232. (a) Under regulations prescribed by the Secretary of Health (subject to subsection (b)), every person who is an employer within the meaning of this title shall be required—

"(1) during the period beginning on the transitional effective date specified in section 301 (c) of the National Health Care Services Reorganization and Financing Act and ending on the day before the effective date specified in section 302 of such Act to provide benefits under such Act equivalent to the hospital insurance benefits available under part A of title XVIII of this Act and the supplementary medical insurance benefits available under part B of such title, and in addition to provide Catastrophic Expense Benefits coverage under and in accordance with section 125 of the National Health Care Services Reorganization and Financing Act, for each of his employees and for the members of the family of each such employee; and

"(2) from and after the effective date specified in section 302 of the National Health Care Services Reorganization and Financing Act, to provide Comprehensive Health Care Benefits coverage (as provided or made available under such Act) to each such employee and for the members of the family of each such employee.

"(b) The provisions of subsection (a) shall not apply—

"(1) (A) with respect to any employer which is the United States or any agency or instrumentality thereof; or

"(B) in any case where the employed member of a family has two or more employers, or where two or more members of the family each have one or more employers, with respect to any such employer other than the one whose total taxes paid under section 3111 (a) of the Internal Revenue Code of 1954 on account of the employment of such member or members is greatest; or

"(2) with respect to any employee (or member of an employee's family) who is entitled to health insurance benefits under title XVIII.

"(c) For purposes of this section the employer's contribution must be at least the actuarial equivalent of 75 percent of the premium cost of the coverage provided by him for his employees as required by subsection (a). The requirement for an employer's contribution shall not in any way prohibit the employee from choosing to register with a Health Care Corporation operating in whole or in part on a capitation basis.

"(d) In any case where an individual who is a low-income person or a member of a low-income family, or who is a medically indigent person or a member of a medically indigent family, is provided with Comprehensive Health Care Benefits coverage by an employer under this section, and in connection therewith is required to make a contribution toward the premium cost of such coverage which exceeds the amount of the premium contribution which he would be required to make under section 106 of the National Health Care Services Reorganization and Financing Act if he were entitled to such coverage under section 102 of that Act rather than under this section, such individual shall be entitled, upon application therefor filed at such time and in such manner and form as the Secretary shall by regulations prescribe, to a premium contribution refund in the full amount of such excess.

"(e) The period of coverage of any employee whose employment is involuntarily terminated shall extend from the date of such termination until the employee becomes eligible for unemployment compensation benefits or until the expiration of 14 days from such termination, whichever first occurs."

(b) Title IX of the Social Security Act is amended by adding at the end thereof the following new section:

"REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR INDIVIDUALS RECEIVING UNEMPLOYMENT COMPENSATION BENEFITS

"SEC. 909. Every individual who is receiving benefits under any Federal or State unemployment compensation law, and the members of his family, shall be entitled under the National Health Care Services Reorganization and Financing Act (while such individual is eligible for and receiving such benefits)—

"(1) during the period beginning on the transitional effective date specified in section 301 (b) of the National Health Care Services Reorganization and Financing Act and ending on the day before the effective date specified in section 302 of such Act, to coverage in the form of (A) benefits under such Act equivalent to the hospital insurance benefits available under part A of title XVIII of this Act and the supplementary medical insurance benefits available under part B of such title, and (B) Catastrophic Expense Benefits coverage under and in accordance with section 125 of the National Health Care Services Reorganization and Financing Act; and

"(2) from and after the effective date specified in section 302 of the National Health Care Services Reorganization and Financing Act, to Comprehensive Health Care Benefits coverage as provided or made available under such Act.

The Secretary of Labor, in accordance with regulations prescribed in consultation with the Secretary of Health, Education, and Welfare, shall purchase such coverage for, and determine the methods by which (and the terms and conditions under which) it is to be made available to, such individuals and members. There are authorized to be appropriated to the Secretary of Labor such sums as may be necessary to carry out this section."

ENTITLEMENT TO BENEFITS FEDERALLY SUBSIDIZED

SEC. 102. (a) Every individual who is a resident of the United States shall, as provided in this section and under the conditions and to the extent otherwise specified in this part, be entitled—

(1) in cases specified in subsection (b), to coverage for Comprehensive Health Care Benefits (as described in this part) contracted for by the Secretary, or

(2) in cases specified in subsection (c), to a Federal contribution to the premium cost of coverage for such benefits under an approved insurance contract or prepayment plan to which the Secretary is not a party.

(b) Such an individual shall be entitled to such coverage contracted for by the Secretary with a carrier under section 217, with respect to any period for which he is not provided with Comprehensive Health Care Benefits coverage by an employer under section 232 of the Social Security Act, if he—

(1) has attained the age of 65, or

(2) is under 65 but is a low-income person or a member of a low-income family, or

(3) is under 65 but is a medically indigent person who complies, or a member of a medically indigent family which complies, with the requirement of section 106 with respect to contributions to premiums for such coverage.

(c) (1) Every other individual referred to in subsection (a) who is registered with an approved Health Care Corporation in a participating State, or with any other organization providing comprehensive health care and services which is engaged in the delivery of such care and services to a defined population group established through open enrollment and has demonstrated such standards as the Secretary may prescribe in order to assure that it will be operated and its services delivered in an effective manner consistent with the purposes and provisions of this Act, shall be entitled to a Federal subsidy of 10 percent of the amount of premium charged by a qualified carrier (as determined under section 132) at an approved group rate for prepaid coverage of the individual for Comprehensive Health Care Benefits under an approved insurance contract or prepayment plan to which the Secretary is not a party. Payments under this subsection shall, upon certification by the Secretary, be made to the carrier.

(2) As used in this subsection, (A) the term "approved group rate" means a group rate prescribed or approved (for the coverage referred to in paragraph (1)) by the State Health Commission (or its delegate agency) under the State plan (approved under part C of title II) of the participating State of which the individual concerned is a resident or, in the case of coverage under an employer plan, the State in which the individual is employed; (B) the term "approved insurance contract or prepayment plan" means an insurance contract or prepayment plan that is approved by the Secretary under section 134; and (C) the term "premium" does not include special premiums payable, in accordance with the provisions referred to in section 134, by a registrant to a carrier to cover the copayment component of capitation charges paid by the carrier to the registrant's Health Care Corporation.

(3) If the coverage of the insurance contract or prepayment plan for an individual (or an individual and his family) entitled to a contribution under paragraph (1) includes Comprehensive Health Care Benefits but also includes benefits greater than those required for Comprehensive Health Care Benefits coverage and a combined premium rate is charged by the carrier for the total coverage, the Federal contribution payable under paragraph (1) shall be based on that portion of the total premium which, in accord-

ance with actuarial principles, is attributable to coverage for Comprehensive Health Care Benefits for that individual (or him and his family) and shall be determined in accordance with regulations of the Secretary.

(4) Entitlement to a contribution under paragraph (1), and the amount thereof, shall be determined without regard to whether the cost of the remainder of the premium is borne (or whether in the absence of that contribution the cost of that portion of the premium which is equal to the contribution would be borne) by the covered individual, by his employer, or by any other person or agency.

(d) For definitions of "low-income person", "low-income family", "medically indigent person", "medically indigent family", and "family", see sections 103 through 105.

INCOME CLASSES

SEC. 103. (a) For purposes of this part—

(1) the terms "low-income person" and "low-income family" mean, respectively, a single individual or family in income class 1;

(2) the terms "medically indigent person" and "medically indigent family" mean, respectively, a single individual or family in income class 2, 3, or 4;

(3) all persons or members of families not in income class 1, 2, 3, or 4 are classified as being in income class 5;

(4) the term "income class", with respect to a single individual or a family, means for any coverage year the individual's or family's income class as determined by application of—

(A) the table set forth in subsection (b) of this section, or

(B) if containing higher dollar amounts, the redetermined income class table promulgated by the Secretary for that year under section 104; and

(5) the term "single individual" means an individual who is not a member of a "family" within the meaning of section 105.

(b) (1) The income class table referred to in subsection (a) (4) (A) is as follows:

TABLE OF INCOME CLASSES

Column I	Column II	Column III	Column IV	Column V
	Family size and income ranges			
Income class	Single individual	Family of 2	Family of 3	Family of 4 or more
1	$0 to $2,000	$0 to $3,000	$0 to $4,500	$0 to $6,000.
2	$2,001 to $3,000	$3,001 to $4,500	$4,501 to $6,000	$6,001 to $7,500.
3	$3,001 to $4,500	$4,501 to $6,000	$6,001 to $7,500	$7,501 to $9,000.
4	$4,501 to $6,000	$6,001 to $7,500	$7,501 to $9,000	$9,001 to $10,500.
5	Above $6,000	Above $7,500	Above $9,000	Above $10,500.

PERIODIC REVISION OF INCOME CLASSES

SEC. 104. (a) Not later than December 31 of each calendar year (after the year in which this Act is enacted), the Secretary shall, in accordance with subsection (b), redetermine and promulgate—

(1) the dollar amounts in the table of income classes under section 103 (b);

(2) the amounts of annual premium contributions to be required of medically indigent persons and medically indigent families under section 106;

(3) the dollar amounts of copayments under section 122; and

(4) for Catastrophic Expense Benefits, the dollar amounts for the special-expenditure limits under section 125.

(b) The redetermined amounts shall be the same as the amounts specified in the respective sections cited in subsection (a) unless the average of the Consumer Price Index for the months of July, August, and September of the calendar year in which the redetermination is made exceeds by 3 percent or more of the average of that index for the corresponding months of the year in which this Act is enacted. In the latter event, the Secretary shall adjust each of the amounts so specified by increasing it by the same percentage as the percentage increase (referred to in the preceding sentence) in the average of the Consumer Price Index, after rounding the latter percentage to the nearest multiple of 0.1 percent (or to the next higher multiple if the percentage is an odd multiple of 0.05 percent) and rounding each dollar amount so obtained—

(1) for the table of income classes, to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50),

(2) for premium contributions to be made by medically indigent persons and medically indigent families, to the nearest multiple of $10 (or to the next higher multiple if the amount to be rounded is an odd multiple of $5),

(3) for copayments, to the nearest multiple of 25 cents (or to the next higher multiple if the amount to be rounded is an odd multiple of 12½ cents), and

(4) for the special-expenditure limits for Catastrophic Expense Benefits, to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50).

(c) The amounts as so redetermined and promulgated in any calendar year (whether or not the same as the amounts specified in the sections cited in subsection (a)) shall be effective for any coverage year that begins in the fiscal year beginning in the following calendar year.

(d) As used in this section, the term "Consumer Price Index" means the Consumer Price Index (All Items—United States City Average) published monthly by the Bureau of Labor Standards of the Department of Labor.

DETERMINATION OF INCOME LEVEL

SEC. 105. (a) For the purposes of this part, the rate of income of a single individual or a family shall be determined on the basis of his adjusted gross income (in the case of a single individual) or the family's combined adjusted gross income (in the case of a family), as defined in accordance with regulations prescribed by the Secretary in consultation with the Secretary of the Treasury or his delegate for the calendar year preceding the coverage year with respect to which the determination is made; except that—

(1) the Secretary may prescribe regulations (A) excluding from the amount thus determined items of income that are not reasonably available for living expenses, and (B) including therein items that are reasonably available for living expenses although not included in adjusted gross income, and

(2) the Secretary may by regulation provide for redetermination of an individual's or family's rate of income on a more current basis when necessary to prevent serious hardship or inequity.

(b) For the purposes of this part—

(1) the term "family" means (A) a husband and wife (not divorced or judicially separated), or (B) such spouses and their dependent unmarried children under 19, or (C) an individual and his or her dependent unmarried children under 19; and

(2) the terms "child" and "dependent" (as applied to a child) have the meanings assigned them in sections 151 and 152 of the Internal Revenue Code of 1954.

PREMIUM CONTRIBUTIONS FOR FEDERALLY CONTRACTED COVERAGE

SEC. 106. (a) (1) In the case of medically indigent persons and members of medically indigent families referred to in section 102 (b) (3), entitlement to coverage contracted for by the Secretary shall be subject to the condition that the individual or family concerned, or another person or agency on the individual's or family's behalf, contribute to the carrier's annual premium charge for such coverage.

(2) (A) The annual amount of contribution so required with respect to such an individual or family shall be—

(i) $50 for a single individual, and $125 for a family, in income class 2;

(ii) $100 for a single individual, and $250 for a family, in income class 3;

(iii) $150 for a single individual, and $375 for a family, in income class 4;

except that in the case of a family (in any such income class) in which only one member is under the age of 65, the amount of contribution required under the foregoing clause applicable to that income class shall be the amount specified in that clause for a single individual, and except that if, by reason of an increase in the Consumer Price Index, higher contribution amounts are promulgated under section 104 by the Secretary with respect to single individuals or families in income class 2, 3, or 4 for any coverage year, those amounts shall apply for that year.

(B) For determination of income classes, see section 103.

(b) Annual contributions under this section shall be payable, by or on behalf of the individual or family concerned, to the carrier under whose contract with the Secretary the individual or family is enrolled, in such installments and in such manner as may be prescribed by the Secretary by regulation. There shall be no recourse against the United States under this title on account of any delinquency or default in the payment of such contributions. For effect of delinquency or default on coverage, see section 136.

INCOME TAX DEDUCTIONS BY INDIVIDUALS

SEC. 107. Section 213(a)(2) of the Internal Revenue Code of 1954 (relating to individual's deduction for medical insurance expense) is amended to read as follows:

"(2) the sum of—

"(A) an amount (not in excess of $150) equal to one-half of the expenses (other than those deductible under subparagraph (B)) paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents (as defined in section 152), and

"(B) in the case of a taxpayer who at any time during the taxable year is covered under an insurance contract or prepayment plan approved by the appropriate State Health Commission under title II of the National Health Care Services Reorganization and Financing Act, an amount equal to—

"(i) all the expenses paid by the taxpayer during the taxable year for Comprehensive Health Care Benefits coverage (as defined in section 122 of the National Health Care Services Reorganization and Financing Act) for the taxpayer and members of his family, reduced by

"(ii) the amount allowable to the taxpayer as a credit for the taxable year under section 42(b)."

INCOME TAX CREDITS FOR CERTAIN PAYMENTS BY EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS FOR COVERAGE

SEC. 108. (a) Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1954 (relating to credits against tax) is amended by redesignating section 42 as section 43 and by inserting after section 41 the following new section:

“SEC. 42. EMPLOYER CREDIT FOR NATIONAL HEALTH SERVICES COVERAGE PAYMENTS IN EXCESS OF 4 PERCENT OF WAGES; COMPARABLE CREDIT FOR THE SELF-EMPLOYED.

“(a) CREDIT FOR EMPLOYERS.—In the case of any employer to whom section 232 (a) of the Social Security Act applies, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to—

“(1) the amount by which (A) such employer’s share of the average premiums payable for the coverage for such taxable year of his employees to whom such section 232 (a) applies, exceeds (B) 4 percent of the average wages paid by such employer to employees for such taxable year, multiplied by

“(2) the number of such employees (not in excess of 10).

“(b) CREDIT FOR SELF-EMPLOYED INDIVIDUALS AND CERTAIN OTHER INDIVIDUALS.—

“(1) ALLOWANCE OF CREDIT.—In the case of an individual who—

“(A) is a resident of the United States, and

“(B) is not provided Comprehensive Health Care Benefits coverage either by an employer under section 232 of the Social Security Act or by the Secretary of Health under section 102 (b) of the

National Health Care Services Reorganization and Financing Act,

there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year the amount determined under paragraph (2).

"(2) AMOUNT OF CREDIT.—The amount of the credit allowable under this subsection to any individual for any taxable year shall be an amount equal to the excess of—

"(A) the aggregate amount of premiums paid by such individual during such taxable year to a qualified carrier (as determined under section 132 of the National Health Care Services Reorganization and Financing Act) at an approved group rate for prepaid coverage of such individual and his family for Comprehensive Health Care Benefits under an approved insurance contract or prepayment plan to which the Secretary of Health is not a party, over

"(B) the sum of—

"(i) 10 percent of the aggregate amount of premiums referred to in subparagraph (A), and

"(ii) 4 percent of the adjusted gross income of such individual for the taxable year, "(c) REGULATIONS.—The Secretary or his delegate shall prescribe such regulations as may be necessary to carry out the purposes of this section. Such regulations shall include, in the case of the credit allowable by subsection (a), rules relating to determining the number of employees of an employer for the taxable year, the wages of the employees, and the premiums payable under the National Health Care Services Reorganization and Financing Act, as well as the method for determining such wages (and the average thereof)."

(b) The table of sections for such subpart A is amended by striking out the item relating to section 42 and inserting in lieu thereof the following:

"Sec. 42. Employer credit for National Health Services coverage payments in excess of 4 percent of wages; comparable credit for the self-employed.
"Sec. 43. Overpayments of tax."

(c) Section 6401 (b) of such Code (relating to refund where credits exceed tax) is amended—

(1) by stiking out "and 667 (b)" and inserting in lieu thereof ", 42 (relating to employer credit for National Health Services coverage payments in excess of 4 percent of wages; comparable credit for the self-employed), and 667 (b)"; and

(2) by striking out "31 and 39" and inserting in lieu thereof "31, 39, and 42".

LIMITATION OF MEDICAID TO SUPPLEMENTATION OF COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 109. (a) On and after the effective date of entitlement to benefits under this part, a participating State (as defined in section 234 (d) (2)) shall, notwithstanding any provision of title XIX of the Social Security Act (relating to grants to States for medical assistance programs), not be required to provide in its State plan under that title for paying under that plan for any service or item (set forth in section 122) that is covered by Comprehensive Health Care Benefits and is furnished to an individual who is entitled to such coverage under section 102. Any amount expended by such a participating State for furnishing any such service or item to such an individual on or after that date (whether or not the service or item is in fact covered under that State plan) shall be disregarded in determining the amount of any payment to be made to the State under title XIX of that Act.

(b) The Secretary shall, with a view to supplementing (so far as practicable), through State plans under title XIX of the Social Security Act, the coverage of Comprehensive Health Care Benefits for individuals referred to in subsection (a), prescribe by regulation the minimum scope of services and items that shall (in lieu of the requirements of section 1902 (a) (13) of that Act) be included, on and after the date referred to in subsection (a), in a State plan as a condition of approval under title XIX of that Act.

PART B—COMPREHENSIVE HEALTH CARE BENEFITS

PAYMENT FOR COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 121. (a) (1) Except as provided in paragraph (2), coverage of a beneficiary for Comprehensive Health Care Benefits shall entitle beneficiaries to have the carrier pay, in accordance with section 152 (b) but subject to the limitations of this part, the approved predetermined charges of Health Care Corporations and other providers for services and items (set forth in section 122) furnished to him and covered by such benefits, or, in those instances in which subsection (b) (3) applies, the charges (approved and submitted to the carrier in accordance with section 243 (f)) of another Health Care Corporation or provider that furnished to him covered services or items. Such coverage is subject to the carrier's right (as provided in section 132 (b)) to reimbursement from the beneficiary in the amount of the copayments (if any) payable under this part, and subject to the other provisions of this part.

(2) In the case of registrants of an approved Health Care Corporation that operates on a capitation charge basis, coverage for Comprehensive Health Care Benefits shall entitle the registrant to have the covering carrier (or the Secretary where the registrant is enrolled under a contract of the Secretary with the corporation under section 135) make payment of capitation charges (instead of fee-for-service

charges) on his behalf in accordance with the applicable provisions of part C of this title. The conditions under which, the manner in which, and the extent to which the amounts of copayments provided for in this part, or the actuarial equivalent of such copayments, is to be paid and collected in such cases, is also governed by part C of this title.

(3) For payment by the carrier to the Health Care Corporation for certain charges not covered by Comprehensive Health Care Benefits, see section 135.

(b) Copayments that are the obligations of beneficiaries shall be paid to the carrier in the amounts specified in the benefit table in section 122, and subject to changes in the Consumer Price Index as determined in sections 104 and 124.

DEFINITION OF COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 122. (a) (1) Comprehensive Health Care Benefits shall, subject to other provisions of this title, consist of benefits for (A) Outpatient Services, (B) Inpatient Services, and (C) Catastrophic Expense Benefits, as described or referred to in the benefit table set forth in subsection (b) and in other provisions of this title. In addition to specific requirements for the issuance of regulations in the table and in other provisions of this part, the Secretary is authorized to issue from time to time such further regulations governing and otherwise adjusting the application of the table as in his judgment will best carry out the purposes of this Act.

(2) For the purposes of the table and of the subsequent provisions of this part—

(A) the term "coverage year" with respect to an individual means a 12-month period of Comprehensive Health Care Benefits coverage of the individual under a qualified carrier's insurance contract or prepayment plan which coincides with a 12-month (annually renewable) term of that contract or plan; and the Secretary shall by regulation provide for application of the table to an individual whose initial enrollment under such a contract or plan occurs after the beginning of a then current 12-mont term of the contract or plan or who is enrolled under a carrier contract with the Secretary that has a shorter initial term;

(B) the term "benefit period" with respect to an individual means a period of consecutive days—

(i) beginning with the first day (not included in a previous benefit period) that occurs during a coverage year and on which he is furnished covered inpatient hospital services, post-hospital extended care services, nursing home care, home health care services, or services under an outpatient institutional-care program for physical disability, mental illness, alcoholism, or drug abuse or drug dependence (as provided in paragraphs A.3.a. and B.1, respectively, of the benefit table), and

(ii) ending with the close of the first period of 60 consecutive days thereafter (whether or not in the same coverage year) on which he is not receiving any of the care or service referred to in clause (i);

(C) the term "regulations" refers to regulations of the Secretary;

(D) the term "outpatient services" means services listed under the heading "Outpatient Services of Health Care Corporations" in the benefit table (including such services to patients confined to the home) and furnished to individuals who are not inpatients covered for services under paragraph B of such table; and

(E) the term "home health care services" means the comprehensive coordinated home care services and the intermediate and basic home health services listed in the benefit table under the heading "Home Health Care Services" and furnished to individuals who are not inpatients covered for services under paragraph B of such table.

For other definitions of terms used in the table, see section 128.

(b) The table referred to in subsection (a) is as follows:

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TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS

I—Services and Items Covered	II—Copayments* and Limitations
A. OUTPATIENT SERVICES	
1. Periodic Health Evaluation	No copayment.
a. Screening tests and examinations, as prescribed by regulations under section 126, followed by physical examination by a physician or physicians when indicated by the screening.	Within such limits as may be prescribed by regulation under section 126.
b. All immunizations.	No copayment and no limitation.
c. Well-Baby Care (for infants under age 5)—	No copayment.
(i) during 1st 12 month following birth;	8 visits.
(ii) during next 12 months;	4 visits.
(iii) during next 3 years.	2 visits per coverage year.
d. Dental Services	
The following professional dental services, including drugs and supplies that are commonly furnished, without separate charge, as an incident to such professional services:	Items d (i) and (ii) in column I apply initially only to children born not more than 7 years before the effective date of this subpart. For those initially covered, the benefits extend through age 12.
(i) Oral examination, including (I) prophylaxis (with fluoride application at appropriate ages), (II) dental X-rays, and (III) in accordance with regulations, other accepted preventive dental procedures.	No copayment. 1 examination per coverage year.
(ii) To the extent prescribed by regulation under section 126 and not covered under (i), above, dental care other than orthodontia; but including, insofar as the Secretary finds that resources of facilities and personnel make practicable, routine extractions, dental fillings, and appropriate prosthetic appliances.	Copayment 20% of charges.

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* The initial amounts of the dollar copayments are subject to changes in the Consumer Price Index as determined under sections 104 and 124.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—Services and Items Covered—Continued	II—Copayments and Limitations—Continued
e. Vision Services (in accordance with regulations under section 126)	For individuals through age 12.
(i) Professional services in routine eye examination, including procedures performed (during the course of an eye examination) to determine the refractive state of the eyes and procedures for furnishing prosthetic lenses, provided either by an ophthalmologist or other physician skilled in diseases of the eye or by an optometrist (whichever the patient may select).	No copayment. 1 visit per coverage year (including therein a follow-up verification of conformity of prescribed lenses with a prescription issued during the visit).
(ii) Eyeglasses with prescription lenses, including the fitting thereof, and including additional lenses and frames as needed.	Copayment 20% of charges. Initially, one set of eyeglasses (including frame and lenses); thereafter, only newly prescribed lenses and frames as required (but not more often than once a coverage year) because of a change in the condition of the eyes. Standards to be established by regulations promulgated by the Secretary in accordance with section 126.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—Services and Items Covered—Continued	II—Copayments and Limitations—Continued
2. Physicians' Services, and Services of Other Qualified Health Professionals and Allied Health Personnel When not otherwise covered under this table—	
a. Physicians' services (including radiotherapy) on an outpatient basis in any appropriate institutional or noninstitutional setting (including home calls), and services in any such setting under a physician's supervision by allied health personnel (as defined in regulations).	For physicians' services, a copayment for each visit of two dollars. Copayments under this paragraph for services in facilities involved in clauses c. and d. below apply only to services of attending physician. Limited to 10 visits per coverage year. Except that, in accordance with regulations, no limit on the number of visits shall apply to services preceding or following inpatient care in cases (such as surgery or pregnancy and obstetrical care) in which a single combined approved charge is made by the provider for such outpatient and inpatient services.
b. Diagnostic procedures on an outpatient basis (when not covered under subparagraph a.), including diagnostic tests, prescribed or ordered by a physician in connection with services referred to in paragraph a.	20% copayment. Copayment requirement waived for registrants of Health Care Corporations. No separate limitation.
c. Hospital or outpatient-center services (not included above) rendered to outpatients and incidental to physicians' services covered under paragraph 1.	No separate copayment. No separate limitation.
d. Supplies, materials, and use of facilities and equipment in connection with the foregoing services, including drugs administered or used as a part of services covered in paragraph 1, 2, or 3.	No separate copayment. No separate limitation.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—Services and Items Covered—Continued	II—Copayments and Limitations—Continued
e. Ambulance services.	20% copayment. Covered only when other methods of transportation are contraindicated by the patient's condition, and only to the extent provided in regulations.
3. Other Outpatient Services a. Outpatient Institutional-Care Program for Physical Disability, Mental Illness, Alcoholism, or Drug Abuse and Dependence.	A two-dollar copayment, per day, except that copayments may, by regulation, be waived for treatment of drug abuse and drug dependence. (No separate copayment for physicians' services applies under this subparagraph, whether or not such services are charged for separately.)
Such day-care or other part-time services and other items as may be specified in regulations under section 126, furnished to patients, other than inpatients, under a program for the rehabilitation of the physically disabled or the treatment of mental illness, alcoholism, or problems of drug abuse and drug dependence.	Limited to visits or sessions on 3 days under such a program in lieu of each day of inpatient hospital care allowable during a benefit period (under paragraph B.1.a. below) for the treatment of physical disability, mental illness, alcoholism, or drug abuse or drug dependence.
b. Drugs, Prosthetic Devices, and Medical Equipment.	
(i) Drugs (other than those covered under paragraph A.1., A.2., or B.1. of this table) dispensed to patients other than inpatients.	For each drug prescription, and each refilling of such a prescription, a one-dollar copayment. Covered only if (1) the drug (whether or not it is subject to a prescription requirement under any law other than this title) has in fact been prescribed by a physician and is listed under its established name (as defined in section 502(e) of the Federal Food, Drug, and Cosmetic Act) in a list established for the purposes of this title by the Secretary under section 126(c), and (2) in the case of a drug listed under section 126(c)(2)(B), the disease or condition for which the drug has been prescribed is one for the treatment of which the drug is designated in that list as appropriate.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—Services and Items Covered—Continued	II—Copayments and Limitations—Continued
(ii) Prosthetic devices (including hearing aids) prescribed by a physician and not otherwise covered in this table.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126.
(iii) In accordance with regulations, durable medical equipment (not otherwise covered) as described in section 1861(s)(6) of the Social Security Act, certified by a physician as being medically required.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126; and subject to criteria for payment prescribed under that section.
c. Home Health Care Services	For each visit, a two-dollar copayment.
(i) Intensive Home Health Care Services.—Services and items defined in section 128(d)(2)(A) furnished to patients who require an intensive level of professionally coordinated medical services that can be provided through a structured home care service in lieu of institutional inpatient care.	Coverage under (i), (ii), or (iii) is limited to a total of 200 days in any benefit period. The certification and recertification requirements of section 1835(a)(2) of the Social Security Act, with such modification (if any) as the Secretary may by regulation prescribe, may be applied by the carrier.
(ii) Intermediate Home Health Care Services.—Services and items as are defined by section 128(d)(2)(B) and regulations thereunder.	
(iii) Basic Home Health Care Services.—Services and items as are defined by section 128(d)(2)(C) and regulations thereunder.	
B. INPATIENT SERVICES	
1. Institutional Services	
a. Inpatient Hospital Care Items and services defined by section 128(e) as "inpatient hospital care."	A five-dollar copayment, per day. Coverage is limited to 90 days of inpatient hospital care received in any benefit period.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—SERVICES AND ITEMS COVERED—Continued	II—COPAYMENTS AND LIMITATIONS—Continued
b. Post-Hospital Extended Care Extended care services (as defined in section 128(b)) furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days. For the purpose of the preceding sentence, the second sentence of section 1861(i) of the Social Security Act shall apply.	A two-dollar-and-fifty-cent copayment, per day. Limited to 30 days of such care received in any benefit period.
c. Nursing Home Care Nursing home care as defined in section 128.	A two-dollar-and-fifty-cent copayment, per day. Coverage shall be limited to 90 days of such care received in any benefit period.
2. Physicians' Services Those physicians' services to inpatients which are not included as "institutional services" under paragraph B.1.a., b., or c.	A two-dollar copayment, per visit of the attending physician only. In accordance with regulations under section 126, in the case of services (such as surgery or pregnancy and obstetrical care) in which a single charge is made by the corporation for the attending physicians' services combined with any preceding or following outpatient services related thereto, a copayment of 10% of such combined charges shall apply. Copayments for physicians services under this paragraph are in addition to the daily copayments for institutional care. No separate **limitations.**

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—SERVICES AND ITEMS COVERED—Continued	II—COPAYMENTS AND LIMITATIONS—Continued
C. CATASTROPHIC EXPENSE BENEFITS	
Section 125 defines the conditions under which these benefits become effective in any coverage year with respect to any individual or family. To summarize: In the case of a low-income person or low-income family (class 1), these benefits are effective immediately. In the case of medically indigent persons or families (classes 2–4), they become effective when the person or family has incurred in a coverage year, for premium contributions, copayments, and certain other expenditures combined, a total expenditure equal to an amount determined by application of a table in section 125. In the case of individuals or families in income class 5, these benefits apply when a variable expenditure limit is reached, determined by taking 10% of the individual's or family's income. The dollar figures in the tables and the absolute expenditure limit may be adjusted by the Secretary on an annual basis, whenever the Consumer Price Index is more than 3% above the index for the base period (see sections 104 and 124).	For elimination of certain limits on coverage for Physicians' Services and Inpatient Hospital Services when Catastrophic Expense Benefits take effect in a coverage year, see section 125. Outpatient care for mental illness is limited to those cases in which active medical treatment (as defined in the last sentence of section 123(a)) is provided. Psychoanalysis is excluded under catastrophic coverage, except in those cases in which it is utilized for the treatment of severe functional disability for which no feasible alternative modes of therapy exist.

LIMITATIONS AND EXCLUSIONS

SEC. 123. (a) Notwithstanding any other provision of this title, Comprehensive Health Care Benefits shall not cover charges for—

(1) services or items that are not medically necessary (or, in the case of health maintenance services under paragraph A. 1. of the benefit table, medically

appropriate), as determined in accordance with regulations and subject to such requirements for certification and recertification by physicians as are specified in this part or in regulations;

(2) inpatient treatment of tuberculosis, mental illness, alcoholism, or problems of drug abuse or drug dependence, unless the condition of the patient is in an acute phase and subject to active medical treatment;

(3) custodial care, other than health-related custodial care;

(4) cosmetic surgery or charges incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(5) personal comfort items;

(6) drugs not prescribed, except when administered by or under the immediate supervision of a physician; or

(7) (A) treatment of flat-foot conditions and the prescription of supportive devices therefor, or

(B) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care).

For purposes of paragraph (2), "active treatment" must be (i) characterized by a written and individualized plan that is based on diagnoses; (ii) based on goals relative to arrest, reversal, or amelioration of the disease process or illness and aimed at restoring the individual's adaptive capacity to the maximum extent possible; (iii) based on objectives relating to such goals; (iv) comprised of defined services and activities; (v) specific as to the means to measure the progress or outcome; and (vi) clear as to periodic review and revision of the plan.

(b) Comprehensive Health Care Benefits shall not cover any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to that item or service under a workman's compensation law or plan of the United States or a State or under a motor vehicle insurance policy or plan. Any payment by the carrier under coverage under this title with respect to any item or service shall be conditioned on reimbursement to the carrier when notice or other information is received that payment for the item or service has been made under such a law, policy, or plan.

(c) Comprehensive Health Care Benefits shall not cover—

(1) charges for items or services (other than emergency services in accordance with section 243 (f)) furnished by a Federal provider of services, except a

provider of services which the appropriate State Health Commission determines is providing services (by arrangement with a Health Care Corporation or otherwise in accordance with part D of title II) as a community institution or agency; or

(2) charges of a Health Care Corporation or other provider for any item or service which the corporation or provider is obligated by a law of, or contract with, the United States to render at public expense.

(d) (1) If the bed and board furnished as part of inpatient institutional services is in accommodations more expensive than semiprivate accommodations, the amount taken into account for purposes of payment with respect to such care under Comprehensive Health Care Benefits coverage may not exceed an amount equal to the approved charges of the Health Care Corporation or nonaffiliated institutional provider for such services if furnished in semiprivate accommodations unless the more expensive accommodations were required for medical reasons.

(2) If the bed and board furnished as part of inpatient services is in accommodations other than, but not more expensive than, semiprivate accommodations and the use of such other accommodations was neither at the request of the patient nor for a reason consistent with the purposes of this Act (as determined under regulations), the amount of

the payment, if any, with respect thereto shall in no event be greater than the corporation's or nonaffiliated provider's approved charge for bed and board in the accommodations furnished.

(3) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(e) If, in any other case, items or services are furnished to an individual in excess of, or more expensive than, items or services with respect to which payment may be made under Comprehensive Health Care Benefits coverage, there shall be taken into account, for purposes of payment by the carrier, only the approved charges of the corporation or other provider with respect to which such payment may be made.

COPAYMENT PROVISIONS

Sec. 124. (a) Except to the extent that Health Care Corporations operate on a predetermined capitation charge basis and do not impose separate charges for services and other items covered by Comprehensive Health Care Benefits at the time such services and items are furnished to a covered individual, and except when Catastrophic Expense Benefits are in effect as determined under section 125, coverage for Comprehensive Health Care Benefits is subject to the payment, by the covered individual or on his behalf by another person or agency, of copayments in the case of services or items with respect to which copayments are specified in the benefit table set forth in section 122, but only if the individual is not a low-income person or a member of a low-income family (as defined in section 103). As provided in sections 121 and 132(b), the amount of such copayments shall not be deducted by the carrier from payment to the Health Care Corporations and other providers for covered services and other items but shall be recovered by the carrier as provided in those sections, without recourse against the corporations and providers.

(b) In those cases in which the table in section 122 specifies as the required copayment a stated percentage of charges with respect to a covered service or item, the amount of the copayment shall, subject to section 123, be equal to that percentage of the approved charges of the provider involved for the covered service or item. In those cases in which the copayment in the table is stated as a dollar amount, if, by reason of an increase in the Consumer Price Index, a higher amount is promulgated for any coverage year under section 104 by the Secretary with respect to any copayment item than the amount specified in the table of benefits for that item, the amount so promulgated shall apply with respect to that year.

CATASTROPHIC EXPENSE BENEFITS

Sec. 125. (a) When Catastrophic Expense Benefits are in effect as a part of coverage for Comprehensive Health Care Benefits with respect to a covered individual in a coverage year, (1) copayments that would otherwise be required to be made by or on behalf of that individual shall not be required with respect to services or items furnished in that coverage year on or after the effective date of those benefits, and (2) the benefit limits shown in column II of the benefit table for physicians' services, and services of other qualified health professionals and allied health personnel (paragraph A. 2. a.), for outpatient institutional-care programs for physical disability, mental illness, alcoholism, or drug abuse or drug dependence (paragraph A. 3. a.), for inpatient hospital care (paragraph B. 1. a.), and for home health care services (paragraph A.3.c.) become inapplicable during that period for those classes of services and care except as otherwise indicated in that column.

(b) (1) In the case of a covered individual who is (or whose family is) in income class 1, with respect to a coverage year, Catastrophic Expense Benefits shall automatically be in effect during the entire year as part of his coverage for Comprehensive Health Care Benefits.

(2) In the case of any covered individual (or his family) in income class 2, 3, or 4, Catastrophic Expense Benefits

shall become effective in a coverage year when the sum of creditable expenditures incurred by him, or incurred by him and all other members of his family in the case of an individual who is a member of a family, equals the amount of a special expenditure limit determined as in the table below (or the amount redetermined by the Secretary for that year under section 104).

SPECIAL EXPENDITURE LIMIT TABLE

Income class	Expenditure limit under 65	Expenditure limit 65 and over
2	$250	$125
3	500	250
4	750	375

(3) In the case of an individual and his family who are in income class 5, the special expenditure limit beyond which Catastrophic Expense Benefits are to take effect shall vary according to the level of income, with the exact limit set at 10 percent of the individual's or family's income (as defined in accordance with the regulations prescribed by the Secretary in consultation with the Secretary of the Treasury or his delegate). The income base to which the 10 percent is to be applied shall be rounded to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50).

(4) The following expenditures incurred by a covered individual, or incurred by him and other members of his family in the case of an individual who is a member of a family, shall be counted as creditable expenditures in deter-

mining under paragraph (2) whether and when Catastrophic Expense Benefits become effective with respect to him in a coverage year:

(A) Expenditures incurred for premiums, or contributions to premiums, for Comprehensive Health Care Benefits coverage (for that year) of that individual, or of him and other members of his family.

(B) Expenditures incurred in that year for copayments under Comprehensive Health Care Benefits coverage, and expenditures for copayments incurred in the last 3 months of the immediately preceding coverage year under such coverage.

(C) (i) Expenditures incurred in the coverage year involved for charges for physicians' services, and services of other qualified health professionals and allied health personnel, described in column I of paragraph A. 2. of the benefit table, or for outpatient institutional care for physical disability, mental illness, alcoholism, or drug abuse or drug dependence as described in paragraph A. 3. a. in that column, or for inpatient hospital care or physicians' services to inpatients described in paragraph B. 1. a. or B. 2. in that column, if those charges were excluded from coverage under such paragraph solely because of the applicable limitations in column II of the benefit table on the number of visits per coverage year or on the number of days of care per benefit period; and (ii) like expenditures incurred in the last 3 months of the immediately preceding coverage year and applied toward the applicable expenditure limit or limits under this section for that year.

(5) For the purposes of this section—

(A) expenditures are (whether or not payment is or has been made) deemed to be incurred—

(i) in the case of the individual's contributions to premiums, when payment is due; or

(ii) in the case of copayments, and of charges described in paragraph (4) (C), when the service or item giving rise to the copayment or charge was provided, unless payment is sooner made; and

(B) expenditures are deemed to be incurred by a covered individual (unless they are Federal payments) if paid or payable by the covered individual or on his behalf by another person or agency.

REGULATIONS FOR COMPREHENSIVE HEALTH CARE BENEFITS

Sec. 126. (a) In addition to any other regulations and standards with respect to the coverage of Comprehensive Health Care Benefits and the various classes thereof, payment of charges to Health Care Corporations for services and items covered thereby, collection of copayments by carriers as provided in section 121 (a), and 132 (b), and other matters relating to such benefits, the Secretary shall issue regulations on the matters required by this section. Section 140, relating to regulations affecting the rights and obligations of carriers, shall also apply to regulations under this part.

(b) The Secretary shall issue regulations amplifying the provisions of the benefit table with respect to Health maintenance benefits covered by paragraph A. 1. of the benefit table and in particular shall—

(1) in the light of the special emphasis of this Act on the obligation of Health Care Corporations for health maintenance, prescribe the coverage of Comprehensive Health Care Benefits with respect to periodic health evaluation as comprehensively as resources of facilities and personnel will permit and with a view to keeping in step with modern developments in this field, and in this connection consider—

(A) insofar as the frequency of evaluations for particular age groups is concerned, the provision of one appropriate evaluation per coverage year for individuals aged 65 or older, one every second year for those aged 19 to 64 inclusive, and one every five years for those aged 5 to 18 inclusive; and

(B) insofar as the components of such evaluations are concerned, including in such coverage, as the Secretary may deem medically appropriate and practicable for the different age, sex, and other patient groups, regularly scheduled complete histories, blood tests, serologies, urinalyses, and other appropriate chemical laboratory tests; chest X-rays; electrocardiograms; Papanicolaou smear tests; rectal and proctoscopic examinations; glaucoma tests; and hearing tests; and

(2) issue regulations with respect to the coverage of paragraph A. 1. c. of the benefit table for vision services.

(c) The Secretary shall issue standards and other regulations with respect to coverage under paragraphs A. 2. and A.3. and paragraph B. of the benefit table, and in particular shall—

(1) define the physicians' and other services, and the drugs and other items, that are to be covered as benefits under paragraph A. 3. a. of the benefit table in outpatient institutional-care programs for physical disability, mental illness, alcoholism, or problems of drug abuse and drug dependence, including considerations of appropriate transportation services for those who are physically disabled, and set forth such criteria for these benefits as will encourage the establishment and use of such programs on a sound basis and lessen the need for

inpatient treatment of these conditions; and waive, or provide for the waiver, of copayments in such programs for the treatment of drug abuse and drug dependence to the extent that the Secretary finds that such waiver is desirable in order to encourage the use of these programs by persons who are in need of such treatment;

(2) for the purpose of coverage of drugs under paragraph A. 3. b. (i) of the benefit table, establish and keep current, on the basis of determinations of the Secretary with respect to the safety and efficacy of the drugs involved—

(A) a list of the categories of drugs that the Secretary finds to be appropriate for the treatment of diseases or conditions requiring drug therapy of such duration and cost as commonly to impose financial hardship; and

(B) a list that (i) designates diseases and conditions, requiring intensive drug therapy (with drugs other than those listed under subparagraph (A)), which the Secretary finds to be of especial importance to the public health, and (ii) specifies with respect to each such disease or condition the category of drugs which the Secretary finds to be appropriate for the treatment thereof;

(3) (A) designate prosthetic devices (including such devices not included under section 1861 (s) of the Social Security Act and including hearing aids) to be covered under paragraph A. 3. b. (ii) of the benefit table and (B) prescribe the conditions for covereage of durable medical equipment (as described in section 1861 (s) of the Social Security Act) under paragraph A. 3. b. (iii) of that table (including criteria for determining whether payment for expensive purchased equipment shall be made on a rental-equivalent basis) ;

(4) (A) (i) prescribe regulations for determining what is to be counted as a visit in the case of physicians' services covered under paragraph A. 2. a. of the benefit table and physicians' services covered under paragraph B. 2. of the table; (ii) prescribe regulations (I) exempting from the limits on the number of visits under paragraph A. 2. a. of the table physicians' services preceding or following inpatient care in cases (such as surgery, or pregnancy and obstetrical care) in which a single combined charge is made, by the provider involved, for any outpatient and inpatient services, and (II) providing for copayments in such cases in an amount equal to a percentage of the combined coverage charges for outpatient and inpatient physicians' services as specified in column II of paragraph B. 2. of the table; and

(5) prescribe regulations, referred to in column II of paragraph A. 3. c. of the benefit table, with respect to the nature and number of visits to be counted for home health services coverage purposes.

PHASING OF ADDITIONAL BENEFITS

SEC. 127. The Secretary shall submit to Congress recommendations for the expansion of benefits after the program is in operation as specified in section 302. The Secretary shall give special consideration to the expansion of benefits for dental and vision services based on the availability of resources.

OTHER DEFINITIONS

SEC. 128. For the purposes of this Act:

(a) The term "drug" means a drug within the meaning of section 201 (g) (1) of the Federal Food, Drug, and Cosmetic Act, as now in force or as hereafter amended, including any product of a kind subject to licensing under section 351 of the Public Health Service Act.

(b) The terms "extended care services" and "nursing home care" mean, respectively, services and items specified as such in regulations of the Secretary (including, in the case of extended care services, the services specified in section 1861 (h) of the Social Security Act) for the respective classes of institutions, if the services are—

(1) furnished to patients who require active inpatient treatment but are not in an acute phase of illness and who currently either require primarily convalescent or restorative services or require primarily health-related custodial care;

(2) furnished under arrangements for the transfer of patients among inpatient care facilities as medically appropriate; and

(3) furnished by an institution which (A) meets the requirements of paragraphs (1) through (9) of section 1861 (j) of the Social Security Act (defining the term "skilled nursing facility" for purposes of title XVIII of that Act), (B) meets such other conditions relating to the physical facilities or to the safety or quality of care of patients as the Secretary may by regulation prescribe for the respective classes of institutions, and (C) is not an institution primarily for the care and treatment of mental illness or tuberculosis.

(c) The terms "skilled nursing care" and "supervision for palliative or terminal care" mean that component of comprehensive health care which—

(1) is furnished to a patient who has a non-curable disease diagnosed by a physician (as defined in section 1861 (r) (1) of the Social Security Act) as still requiring medical or nursing care (or both), for pallia-

tion or as terminal care, through extended care services or nursing home care or home health care services or physicians' home calls;

(2) has the purpose of maintaining the well-being of that patient to the maximum degree possible; and

(3) involves a patient who either—

(A) is bedridden, or unable to get into and out of bed without assistance, or

(B) requires nursing care procedures (such as complicated dressings, irrigations, or intravenous medications) that cannot be performed by the patient or by nonnursing personnel (such as a family member or companion), or

(C) experiences frequent episodes of sudden, acute illness requiring emergency treatment that cannot be controlled by medication (such as uncontrolled diabetes, epilepsy, paroxysmal tachycardia, or fibrillation), or

(D) requires constant physical restraints to prevent injury to himself or others (as in the case of senile patients or patients who suffer from certain mental illnesses).

(d) (1) The term "home health care services" means (subject to paragraph (3)) the three different concentrations of health care services furnished to an individual in his home or place of residence by an affiliated hospital, home health agency, or outpatient center specified in paragraph (2) if—

(A) they are furnished to an individual who is under the care of a physician;

(B) they are furnished by a Health Care Corporation either directly or through the home care department of an affiliated hospital provider or through an affiliated provider that is a "home health agency" as defined in section 1861 (o) of the Social Security Act (but not excluding an agency or organization that is primarily for the care and treatment of mental illness);

(C) they are furnished under a plan, established and periodically reviewed by a physician, for furnishing them to the individual; and

(D) they are, except as otherwise provided in paragraph (2), furnished on a visiting basis in a place of residence used as the individual's home.

(2) The different concentrations of home health care services referred to in paragraph (1) are—

(A) intensive home care services, the furnishing of which involves the professional coordination by a registered nurse of a complex of health services, under medical direction, that may include—

(i) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(ii) physical, respiratory, occupational, or speech therapy;

(iii) medical social services by referral of a physician;

(iv) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(v) diagnostic and therapeutic items or services, furnished by a hospital or outpatient center, which are ordinarily furnished to inpatients of the hospital, to the extent they are medically appropriate and it is feasible to provide them to patients in their homes;

(vi) drugs, medical supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of inpatients, to the extent they are necessary to carry out the physician's plan of treatment for the patient and it is feasible to provide them to patients in their homes;

(vii) such physicians' services in the hospital or outpatient center (such as those of radiologists and pathologists) as are held out as generally available to all inpatients of a hospital and which are charged for by the hospital or outpatient center as part of its services;

(viii) medical services provided by an intern or a resident-in-training in a provider institution to a patient in his place of residence or an outpatient center; and

(ix) ambulance or other special transportation services when other methods of transportation are contraindicated by the patient's condition to transport the patient from a provider institution to his place of residence or from his place of residence to a hospital or outpatient center to receive services the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his place of residence;

(B) intermediate home health care services, including the following items and services provided either directly or through an affiliated home health agency provider as specified in paragraph (1) (B):

(i) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(ii) physical, occupational, or speech therapy;

(iii) medical social services under the direction of a physician;

(iv) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(v) medical supplies (other than drugs), and the use of medical appliances and equipment, while under the plan referred to in paragraph (1) (C);

(vi) medical services provided by an intern or resident-in-training in an affiliated home health agency provider; and

(vii) any of the foregoing items and services

(I) which are provided on an outpatient basis, under arrangements made by the Health Care Corporation or home health agency referred to in paragraph (1) (B), at a hospital, skilled nursing facility, or rehabilitation center, and

(II) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in the place of residence referred to in paragraph (1) (D); or which are furnished at that hospital, facility, or center while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service except ambulance service when other methods of transportation are contraindicated by the patient's condition, and only to the extent provided in regulations; and

(C) basic home health services, which are furnished either directly or through an affiliated home health agency provider as specified in paragraph (1) (B) to individuals requiring "palliative and terminal care", including the following:

(i) part-time or intermittent nursing provided by or under the supervision of a registered professional nurse;

(ii) medical social service including counseling;

(iii) part-time or intermittent home health aide services assigned and supervised by a registered professional nurse; and

(iv) medical supplies (other than drugs), and the use of medical appliances and equipment, while under the plan referred to in paragraph (1) (C).

(3) Notwithstanding the provisions of paragraphs (1) and (2), the term "home health care services" does not include any item or service if it would not be included under

"inpatient hospital care" (as defined in subsection (e)) if furnished to an inpatient of a hospital.

(e) The term "inpatient hospital care" means the following items and services furnished to an inaptient of a hospital and, except as otherwise specified, by the hospital:

(1) Bed and board.

(2) Such physicians' services in the hospital (such as those of radiologists and pathologists) as are held out as generally available to all inpatients of a hospital and which are charged for by the hospital as part of its services.

(3) Such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients.

(4) Such other diagnostic or therapeutic items or services, furnished by the hospital, as are ordinarily so furnished to inpatients of the hospital.

(f) (1) The term "physician" means, except when otherwise specified, a physician as defined in section 1861 (r) of the Social Security Act.

(2) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls.

(3) The term "attending physician" means, with respect to a patient, the physician having primary responsibility for the patient's medical care.

BENEFITS

DEFINITION OF "CARRIER"

SEC. 131. As used in this Act, the term "carrier" means—

(1) a voluntary association, corporation, partnership, or other nongovernmental organization that is engaged in providing, paying for, or reimbursing the cost of, health care under insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of predetermined premiums or other periodic charges payable to the carrier; and

(2) a Health Care Corporation approved by a State Health Commission under a State plan approved by the Secretary under this Act, to the extent that the corporation charges for covered health care on an annually predetermined capitation basis in accordance with section 246(b).

DETERMINATION OF QUALIFIED CARRIER; HEALTH CARD

SEC. 132. A carrier is a qualified carrier for the purposes of this Act if—

(1) (A) the carrier is authorized to operate health benefit prepayment plans or insurance at group rates in each State for whose residents it provides, or proposes to provide, coverage under this Act, is in compliance with section 133, and meets such additional standards as the Secretary may establish, including, in the case of contracts with the Secretary under sections 102 and 106, any special standards established for the purposes of those sections; and

(B) with respect to coverage for which a premium contribution by the Secretary is requested under section 102 (c), the carrier agrees to accord to the Secretary and his agents the same rights to information and access to the carrier's records as is required to be accorded to them under section 141; and

(2) the carrier provides, consistent with section 212 (b) (6), that—

(A) an account will be established against which a covered individual may charge the cost of obtaining items and services covered under this Act, without regard to the copayment requirements applicable under this Act;

(B) payment for items and services covered under this Act, other than emergency services, will be made only on the basis of charges against that account;

(C) payment will be made on the basis of charges against the account for items and services covered under this Act at the applicable payment rates; and, unless the account is in default, payment will be made to participating providers for all items and services, without reduction on account of the copayment requirements applicable under this Act and the covered individual will be billed the portion of any payment properly chargeable to him on account of those copayment requirements; and

(D) credit will be available with respect to any bill submitted to a covered individual pursuant to subparagraph (C) and interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary, with no recovery being made from any individual or entity to whom payment has been made because of the failure of a covered individual to pay any such bill; and an account will not be regarded as in default unless payment of amounts due under the account, or any other such account established with respect to the covered individual pursuant to the requirements of this title, is 90 days in arrears.

REQUIREMENT THAT CARRIERS PARTICIPATE UNDER STATE PLANS

SEC. 133. A carrier shall not be qualified for award of a contract with the Secretary under section 102 or 106 or for issuance of Comprehensive Health Care Benefits coverage eligible for a premium subsidy under section 102 (c), unless the carrier agrees, if required by the appropriate State Health Commission (or its delegate agency) of a State, to participate in a coverage pool in accordance with provisions therefor contained in the State plan pursuant to section 234 (b) (7), or unless the carrier is in fact such a participant.

CONDITIONS OF APPROVAL OF CARRIER CONTRACTS OR PLANS FOR FEDERAL PREMIUM SUBSIDY

SEC. 134. The Secretary shall, for the purpose of any premium contribution under section 102, approve an insurance contract or prepayment plan of a carrier (including such a contract or plan under State plan provisions referred to in section 234 (b) (7)) only if the insurance contract or prepayment plan—

(1) is in conformity with applicable regulations and standards prescribed under the State plan (approved under part C of title II) of the appropriate participating State;

(2) provides for 12-month coverage terms;

(3) does not permit any exclusion from, or limitation with regard to, coverage of an individual because of health status (pre-existing, current, or future), economic status, race, sex, occupation, age or establishment of any other condition inconsistent with regulations of the Secretary but this paragraph shall not be construed to preclude reasonable classification of risks for premium rate purposes in accordance with actuarial principles; and

(4) contains such provisions as the Secretary may prescribe or approve relating to coordination of the coverage under the insurance contract or prepayment plan involved with overlapping or duplicative coverages under other insurance contracts or prepayment plans.

CONTRACTS WITH HEALTH CARE CORPORATIONS ON CAPITATION BASIS

SEC. 135. In the case of a Health Care Corporation that operates on the basis of predetermined capitation charges (approved by the appropriate State Health Commission), the Secretary may, if satisfied as to the corporation's financial responsibility to qualify as a carrier for itself under this section, provide the coverage for Comprehensive Health Care Benefits under this Act to which registrants of the corporation are entitled under section 102 (b), by entering (directly or through the State Health Commission as the Secretary's agent as authorized by section 217 (b) (2)) into a contract with the corporation, whereby the Secretary, in consideration of the corporation's undertaking to provide (or, when authorized under part D of title II, pay for) the services and items covered by such benefits, agrees that there shall be paid by the Secretary to the corporation, with respect to those registrants of the corporation who enroll under the contract, the same amounts that a third-party carrier would be required to pay under a contract with the Secretary, except that a contract under this section—

(1) shall authorize the Secretary in the case of a Health Care Corporation that does not impose separate charges equivalent to copayments in addition to capitation charges, to deduct, from any capitation payments otherwise payable by the Secretary to the corporation on behalf of an individual enrolled under the contract, the value (as determined on the basis of actuarial principles) of any copayments to which the covered registrants would be subject under part B of this title if the corporation imposed separate charges equivalent to copayments;

(2) shall not, in the case of a Health Care Corporation that imposes separate charges equivalent to copayments in addition to capitation charges, undertake to pay those charges to the corporation;

(3) shall provide that the corporation shall itself collect from a registrant (or from others on his behalf) all copayments and premium contributions (in the form of capitation charges) payable by the registrant, and shall keep for the registrant the record of such copayments and contributions incurred by him (or his family) and notify him when he has reached the applicable expenditure limit under section 125 giving rise to Catastrophic Expense Benefits; and

(4) shall require the corporation to establish, in accordance with regulations or with provisons in the contract, effective procedures (through such means as establishment of a separate record and payment center and issuance of identical membership cards to all its registrants, regardless of whether they have benefit coverage purchased by the Secretary) that will prevent persons who furnish health services or items for the corporation from identifying those registrants who enjoy coverage purchased by the Secretary and discriminating against them on that account.

Any reference in this part to premiums, or contributions to premiums, shall be deemed to include capitation amounts paid by the Secretary, or contributions to capitation charges by registrants, respectively, under contracts made under this section.

EFFECT OF NONPAYMENT OF PREMIUMS

SEC. 136. (a) Premium contributions and special premiums payable pursuant to section 106, by individuals referred to therein who are enrolled under a contract under this title, shall be paid by or on behalf of the registrant to the carrier (from sources other than the Secretary) in periodic installments in advance in a manner and at the time or times perscribed in regulations of the Secretary but not less often than quarterly nor more often than monthly.

(b) In the event of nonpayment of a contribution or special premium installment, when due, to the carrier by or on behalf of an individual, the benefit coverage to which the overdue installment relates shall, upon notice by the carrier in accordance with regulations of the Secretary, end unless payment is made prior to the expiration of a grace period (not in excess of 90 days) prescribed by the regulations, except that (1) the manner and order of termination of coverage of family members in the event of partial delinquency or default in family contribution installments payable under section 106 shall be determined in accordance with regulations, (2) delinquency or default in contribution installments under section 106 shall not affect the coverage of any family member who has attained the age of 65, and (3) delay in payment shall not give rise to termination of coverage if attributable to an act or omission of a Federal officer or employee used as a conduit for transmitting such installments.

ENROLLMENT UNDER CONTRACTS WITH CARRIERS

SEC. 137. (a) The Secretary may by regulations consistent with other provisions of this Act, prescribe the time or times at which, the manner in which, and the conditions under which individuals may (1) enroll, under a contract made under this part, for Comprehensive Health Care Benefits coverage purchased by the Secretary to which under section 102 they are entitled, or (2) change enrollment under one contract to enrollment under another.

(b) The regulations under this section shall permit enrollment by an individual for himself only, or for himself and his spouse and other individuals who are members of his family (as defined in section 105(b)), and shall prescribe the times at which, the manner in which, and the conditions under which a change from one such type of enrollment to another may be made. An individual enrolling for himself and family shall be liable for any premium contributions on which entitlement to family coverage is conditioned.

(c) To the optimum extent, (1) open enrollment periods under this section and open periods for registration with Health Care Corporations approved by State commissions under approved State plans under this Act shall be closely coordinated, to the end that registration and enrollment, and changes therein, may be effected concurrently, and (2) registration centers of Health Care Corporations shall function also as centers at which to apply for, and obtain information concerning, enrollment.

REPORTS BY AND AUDITS OF CARRIERS

SEC. 138. Consistent with section 212(b)(6), each contract with a carrier under this title, including contracts with Health Care Corporations qualifying as carriers and contracting with respect to their registrants, shall require the carrier to make such reports, in such form, and containing such information as the Secretary or his agents may require to carry out their functions under this Act, and to keep such records and afford such access thereto as the Secretary or his agents may find necessary to assure the correctness and verification of the reports and otherwise to carry out its functions under this Act.

JURISDICTION OF COURTS

SEC. 139. The district courts of the United States shall have original jurisdiction, concurrent with the Court of Claims, of a civil action or claim against the United States founded on this part.

PROSPECTIVE REGULATIONS

SEC. 140. Regulations, amendments to regulations, or amendments to this Act, issued or enacted during an annual contract term under this title, shall not, to the extent that their application would increase the obligations or adversely affect the rights of the contracting carrier, apply to that contract until the next contract year unless made applicable by the contract or by amendment thereto.

TITLE II—REORGANIZATION OF NATIONAL HEALTH SERVICES

SHORT TITLE

Sec. 200. This title may be cited as the "National Health Care Services Reorganization Act".

Part A—Department of Health

ESTABLISHMENT OF DEPARTMENT

Sec. 201. (a) There is established at the seat of government an executive department to be known as the Department of Health (hereinafter in this Act referred to as the "Department"). There shall be at the head of the Department a Secretary of Health (hereinafter in this Act referred to as the "Secretary"), who shall be appointed by the President, by and with the advice and consent of the Senate.

(b) There shall be in the Department an Under Secretary, who shall be appointed by the President, by and with the advice and consent of the Senate. The Under Secretary (or, during the absence or disability of the Under Secretary, or in the event of a vacancy in the office of Under Secretary, an Assistant Secretary or the General Counsel, determined according to such order as the Secretary shall prescribe) shall act for, and exercise the powers of, the Secretary during the absence or disability of the Secretary or in the event of a vacancy in the office of Secretary. The Under Secretary shall perform such functions as the Secretary shall prescribe from time to time.

(c) There shall be in the Department seven Assistant Secretaries and a General Counsel, who shall be appointed by the President by and with the advice and consent of the Senate, and who shall perform such functions as the Secretary shall prescribe from time to time.

(d) There shall be in the Department a Chief Medical Officer who shall be appointed by the President, by and with the advice and consent of the Senate, without regard to political affiliation and solely on the basis of fitness to perform the duties of the position. The term of office of the Chief Medical Officer shall be six years, except that an individual serving as Chief Medical Officer may upon the expiration of his term of office continue to serve until his successor shall have been appointed and qualified.

TRANSFERS TO SECRETARY AND CHIEF MEDICAL OFFICER

SEC. 202. (a) Except as provided in subsection (b), there are transferred to the Secretary all functions of the Secretary of Health, Education, and Welfare under the following laws and provisions of law:

(1) The Public Health Service Act.

(2) The Family Planning Services and Population Research Act of 1970.

(3) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(4) Section 232 of the National Housing Act (relating to mortgage insurance for nursing homes).

(5) Title XI of the National Housing Act (relating to mortgage insurance for group practice facilities).

(6) The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

(7) Section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

(8) The Controlled Substances Act.

(9) The Act of August 5, 1954 (42 U.S.C. 2001–2004a) (relating to hospital and other health facilities for Indians).

(10) The Act of August 16, 1957 (42 U.S.C. 2005–2005f) (relating to community hospitals for Indians).

(11) Chapter 175 of title 28 of the United States Code (relating to civil commitment and rehabilitation of narcotic addicts).

(12) Chapter 314 of title 18 of the United States Code (relating to sentencing of narcotic addicts to commitment for treatment).

(13) Title III of the Narcotic Addict Rehabilitation Act of 1966 (relating to civil commitment of persons not charged with any criminal offense) and section 602 of such Act.

(14) The Federal Cigarette Labeling and Advertising Act.

(15) The Federal Food, Drug, and Cosmetic Act.

(16) The Federal Hazardous Substances Act.

(17) The Poison Prevention Packaging Act of 1970.

(18) The Fair Packaging and Labeling Act.

(19) The Act of March 2, 1897 (21 U.S.C. 41–50) (relating to tea importation).

(20) The Act of March 4, 1923 (21 U.S.C. 61–64) (relating to filled milk).

(21) The Act of February 15, 1927 (21 U.S.C. 141–149) (relating to importation of milk).

(22) The Federal Caustic Poison Act.

(23) The Flammable Fabrics Act.

(24) The Federal Coal Mine Health and Safety Act of 1969 (other than title IV thereof).

(25) The District of Columbia Medical Facilities Construction Act of 1968.

(26) The Occupational Safety and Health Act of 1970.

(27) The Lead-Based Paint Poisoning Prevention Act.

(28) Titles XVIII, XIX, II, and V of the Social Security Act insofar as such titles relate to the provision of health care services.

(29) The District of Columbia Medical and Dental Manpower Act of 1970.

(30) The Drug Abuse Office and Treatment Act of 1972.

(b) The functions of the Secretary of Health, Education, and Welfare respecting (1) the commissioned Regular Corps and Reserve Corps of the Public Health Service, (2) the administration of section 329 of the Public Health Service Act (relating to assignment of health personnel of the Public Health Service to critical need areas), and (3) the administration and operation of health care delivery facilities of the Public Health Service shall be exercised by the Chief Medical Officer under the supervision and direction of the Secretary of Health.

(c) Within one hundred and eighty days of the effective date of this part the President may transfer to the Secretary any function not transferred to the Secretary by subsection (a) of this section, if the Director of the Office of Management and Budget determines such function (1) relates primarily to functions transferred by such subsection to the Secretary, or (2) otherwise relates to health.

REDESIGNATION OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SEC. 203. (a) The Department of Health, Education, and Welfare, the Secretary of Health, Education, and Welfare, the Under Secretary of Health, Education, and Welfare, the Assistant Secretaries of Health, Education, and Welfare, the General Counsel of the Department of Health, Education, and Welfare, and the Assistant Secretary of Health, Education, and Welfare for Administration shall on and after the effective date of this part be known and designated as the Department of Education and Welfare, the Secretary of Education and Welfare, the Under Secretary of Education and Welfare, the Assistant Secretaries of Education and Welfare, the General Counsel of the Department of Education and Welfare, and the Assistant Secretary of Education and Welfare for Administration, respectively.

(b) Any reference in a law, regulation, document, or other record of the United States to the Department of Health, Education, and Welfare or an office the title of which is redesignated by subsection (a) of this section shall be held and considered to be a reference to the Department of Education and Welfare or to such office as so redesignated.

ADMINISTRATIVE PROVISIONS

SEC. 204. (a) In addition to the authority contained in any other Act which is transferred to the Secretary, the Secretary is authorized, subject to the provisions of title 5, United States Code, relating to appointments in the competitive service and to classification and General Schedule pay rates, to select, appoint, employ, and fix the compensation of such officers and employees, including investigators, attorneys, and hearing examiners, as are necessary to carry out his functions and to prescribe their authority and duties.

(b) The Secretary may obtain services as authorized by section 3109 of title 5, United States Code, but at rates for individuals not to exceed the daily equivalent of the rate in effect for grade GS–18 of the General Schedule, unless otherwise specified in an appropriation Act.

(c) The Secretary may, in addition to the authority to delegate and redelegate contained in any other Act, in the exercise of the functions transferred to the Secretary by this part, delegate any of his functions to such officers and employees of the Department as he may designate, may authorize such successive redelegations of such functions as he may deem desirable, and may make such rules and regulations as may be necessary to carry out his functions.

(d) So much of the positions, personnel, assets, liabilities, contracts, property, records, authorizations, allocations, and other funds employed, held, used, arising from, available or to be made available, in connection with the functions transferred by section 202 as the Director of the Office of Management and Budget shall determine shall be transferred to the Secretary. Except as provided in subsection (e), personnel engaged in functions transferred under this part shall be transferred in accordance with applicable laws and regulations relating to transfer of functions.

(e) The transfer of personnel pursuant to subsection (d) of this section shall be without reduction in classification or compensation for one year after such transfer.

(f) In any case where all of the functions of any office or agency are transferred pursuant to this part, such office or agency shall lapse.

(g) The Secretary is authorized to establish a working capital fund to be available without fiscal year limitation, for expenses necessary for the maintenance and operation of such common administrative services as he shall find to be desirable in the interest of economy and efficiency in the Department, including such services as a central supply service for stationery and other supplies and equipment for which adequate stocks may be maintained to meet in whole or in part the requirements of the Department and its agencies;

central messenger, mail, telephone, and other communications services; office space, central services for document reproduction, and for graphics and visual aids; and a central library service. The capital of the fund shall consist of any appropriations made for the purpose of providing capital (which appropriations are hereby authorized) and the fair and reasonable value of such stocks of supplies, equipment, and other assets and inventories on order as the Secretary may transfer to the fund, less the related liabilities and unpaid obligations. Such fund shall be reimbursed in advance from available funds of agencies and offices in the Department, or from other sources, for supplies and services at rates which will approximate the expense of operation, including the accrual of annual leave and the depreciation of equipment. The fund shall also be credited with receipts from sale or exchange of property and receipts in payment for loss or damage to property owned by the fund. There shall be covered into the United States Treasury as miscellaneous receipts any surplus found in the fund (all assets, liabilities, and prior losses considered) above the amounts transferred or appropriated to establish and maintain such fund.

(h) The Secretary may approve a seal of office for the Department, and judicial notice shall be taken for such seal.

(i) In addition to the authority contained in any other Act which is transferred to and vested in the Secretary, as necessary, and when not otherwise available, the Secretary is authorized to provide for, construct, or maintain the following for employees and their dependents stationed at remote localities:

(1) Emergency medical services and supplies;

(2) Food and other subsistance supplies;

(3) Messing facilities;

(4) Motion picture equipment and film for recreation and training; and

(5) Living and working quarters and facilities.

The furnishing of medical treatment under paragraph (1) and the furnishing of services and supplies under paragraphs (2) and (3) of this subsection shall be at prices reflecting reasonable value as determined by the Secretary, and the proceeds therefrom shall be credited to the appropriation from which the expenditure was made.

(j) The Secretary is authorized to accept, hold, administer, and utilize gifts and bequests of property, both real and personal, for the purpose of aiding or facilitating the work of the Department.

(k) The Secretary is authorized to appoint, without regard to the provisions of title 5, United States Code, relating to appointments in the competitive service, such advisory committees as may be appropriate for the purpose of consultation with and advice to the Department in performance of its functions. Members of such committees, other than those regularly employed by the Federal Government, while attending meetings of such committees or otherwise serving at the request of the Secretary, may be paid compensation at rates not exceeding those authorized for individuals under subsection (b) of this section, and while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

(l) (1) The Secretary is authorized to enter into contracts with educational institutions, public or private agencies or organizations, or individuals for the conduct of research into any aspect of the problems related to the programs of the Department which are authorized by statute.

(2) The Secretary may from time to time disseminate in the form of reports or publications to public or private agencies or organizations, or individuals such information as he deems pertinent on the research carried out pursuant to this subsection.

(3) Nothing contained in this subsection is intended to amend, modify, or repeal any provision of law administered by the Department which authorizes the making of contracts for research.

ANNUAL REPORT

SEC. 205. The Secretary shall, as soon as practicable after the end of each fiscal year, make a report in writing to the President for submission to the Congress on the activities of the Department during the preceding fiscal year.

SAVINGS PROVISIONS

SEC. 206. (a) All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges—

(1) which have been issued, made, granted, or allowed to become effective in the exercise of any function transferred by this part, and

(2) which are in effect at the time this part takes effect,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or repealed by the Secretary, by any court of competent jurisdiction, or by operation of law.

(b) This part shall not affect any proceedings pending at the time this section takes effect before any officer, any function of whom is transferred by this part; but such proceedings, to the extent that they relate to functions so transferred, shall be continued before the Department. Such proceedings, to the extent they do not relate to functions so transferred, shall be continued before the officer before whom they were pending at the time of such transfer. In either case orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this part had not been enacted; and orders issued in any such proceedings shall continue in effect until modified, terminated, superseded, or repealed by the Secretary, by a court of competent jurisdiction, or by operation of law.

(c) (1) Except as provided in paragraph (2)—

(A) the provisions of this part shall not affect suits commenced prior to the date this section takes effect, and

(B) in all such suits proceedings shall be had, appeals taken, and judgments rendered, in the same manner and effect as if this part had not been enacted.

No suit, action, or other proceeding commenced by or against any officer in his official capacity shall abate by reason of the enactment of this part. Causes of action, suits, actions, or other proceedings may be asserted by or against the United States or such official of the Department as may be appropriate and, in any litigation pending when this section takes effect, the court may at any time, on its own motion or that of any party, enter an order which will give effect to the provisions of this subsection.

(2) If before the date on which this part takes effect any officer in his official capacity is a party to a suit, and

under this part any function of such officer is transferred to the Secretary, then such suit shall be continued by the Secretary (except in the case of a suit not involving functions transferred to the Secretary, in which case the suit shall be continued by the officer who was a party to the suit prior to the effective date of this part).

(d) With respect to any function transferred by this part and exercised after the effective date of this part, reference in any other Federal law to any officer, any function of whom is so transferred shall be deemed to mean the officer in whom this title vests such function after such transfer.

(e) Orders and actions of the Secretary in the exercise of functions transferred under this part shall be subject to judicial review to the same extent and in the same manner as if such orders and actions had been by the officer exercising such functions, immediately preceding their transfer. Any statutory requirements relating to notice, hearings, action upon the record, or administrative review that apply to any function transferred by this part shall apply to the exercise of such function by the Secretary.

(f) In the exercise of the functions transferred under this part, the Secretary shall have the same authority as that vested in the officer exercising such functions immediately preceding their transfer, and the Secretary's actions in exercising such functions shall have the same force and effect as when exercised by such officer.

CODIFICATION

SEC. 207. The Secretary is directed to submit to the Congress within two years from the effective date of this part a proposed codification of all laws which contain functions transferred to the Secretary by this part.

DEFINITION

SEC. 208. For purposes of this part, the term "function" includes power and duty.

CONFORMING AMENDMENTS

SEC. 209. (a) Section 19(d)(1) of title 3, United States Code, is amended by striking out "Secretary of Health, Education, and Welfare" and inserting in lieu thereof "Secretary of Education and Welfare", and by inserting before the period at the end thereof the following: ", Secretary of Health".

(b) Section 101 of title 5, United States Code, is amended by striking out "Health, Education," in the antepenultimate paragraph and inserting in lieu thereof "Education" and by inserting below the last paragraph the following:

"The Department of Health".

(c) Subchapter II (relating to executive schedule pay rates) of chapter 53 of title 5 of the United States Code is amended as follows:

(1) Section 5312 is amended by striking out "Health, Education," in paragraph (10) and inserting in lieu thereof "Education", and by adding below paragraph (12) the following:

"(13) Secretary of Health."

(2) Section 5314 is amended by striking out "Health, Education," in paragraph (6) and inserting in lieu thereof "Education", and by adding below paragraph (60) the following:

"(61) Under Secretary of Health."

(3) Section 5315 is amended by striking out "Health, Education," in paragraphs (17) and (41) and inserting in lieu thereof "Education", and by adding after paragraph (104) the following:

"(105) General Counsel, Department of Health.

"(106) Assistant Secretaries of Health (7)."

(4) Section 5316 is amended by striking out "Health, Education," in paragraphs (24), (51), (52), and (53) and inserting in lieu thereof "Education".

(5) Paragraph (43) of section 5316 is amended by striking out ", Education, and Welfare".

(6) Section 5317 is amended by striking out "34" and inserting in lieu thereof "36".

EFFECTIVE DATE; INITIAL APPOINTMENT OF OFFICERS

SEC. 210. (a) This part and the amendments made by this part shall take effect ninety days after its enactment, or on such prior date after enactment of this Act as the President shall prescribe and publish in the Federal Register.

(b) Any of the officers provided for in this part may (notwithstanding subsection (a)) be appointed in the manner provided for in this part, at any time after the date of enactment of this Act. Such officers shall be compensated from the date they first take office, at the rates authorized by this part. Such compensation and related expenses of their offices shall be paid from funds available for the functions to be transferred to the Department pursuant to this part.

PART B—FEDERAL ADMINISTRATION OF HEALTH CARE PROGRAMS

FUNCTIONS AND RESPONSIBILITIES OF THE SECRETARY

SEC. 211. (a) The Secretary shall be charged with responsibility for the planning, administration, operation, coordination, and evaluation of all programs transferred to him under part A of this title as well as the health care program under this Act.

(b) With respect to the program under this Act, the Secretary shall be specifically charged with responsibility for—

(1) continuous review of the activities of State Health Commissions;

(2) liaison with all Federal agencies administering health or health-related programs, and with private national accrediting and other agencies concerned with standards of care and qualifications of health personnel, including the approval and listing of certifying bodies;

(3) annual reports, to be transmitted through the Secretary to the President, first to evaluate the progress of State plans and the development of health care corporations, and thereafter to evaluate the national program, including recommendations for legislation, if any; and

(4) dissemination to State governments, and to providers of service and the public, of all pertinent information about the national program, and to State governments, providers of service, and potential sponsors of health care corporations of information concerning the organization and responsibilities of such corporations.

REGULATIONS OF THE SECRETARY

Sec. 212. (a) In addition to regulations specifically required or authorized by this title, the Secretary is authorized to prescribe such further regulations, not inconsistent with law, as he deems necessary to the efficient administration of the title. Regulations shall be issued in accordance with the provisions of section 553 of title 5, United States Code.

(b) In addition to authority otherwise conferred by this title, the Secretary is authorized to prescribe by regulation—

(1) standards for systems of accounting that can provide guidance to State Health Commissions in developing such systems adapted to individual State needs, such systems to determine the reasonableness of the budgets and charges of Health Care Corporations and other providers of health care; and standards for a national system or systems of reporting and billing;

(2) the method or methods to be used, and the elements to be considered, in determining, for the purposes of section 246, the financial requirements of Health Care Corporations and other providers, including—

(A) for such corporations and for institutions—

(i) requirements for direct and indirect expenses for patient care services, including such services to indigents with respect to whom payment by or for the patient is waived in whole or in part by the corporation or institution, but reduced by the amount of any grants (including income from endowments) earmarked by the donor or reserved by the governing body of the corporation or institution for payment for such services;

(ii) requirements to defray any deficit of approved education or training programs and of approved research programs;

(iii) requirements for minor remodeling of facilities;

(iv) requirements for current operating needs (working capital) or to meet contingencies;

(v) requirements for allowable interest on funds borrowed;

(vi) requirements to meet other operating expenses required to meet standards imposed under this Act, such as patient education programs;

(vii) requirements of specific price level depreciation to establish and perpetuate a revolving fund to meet ongoing expenditures for the purchase of major movable equipment;

(viii) requirements of general price level depreciation on other plant and equipment facilities for the maintenance and preservation of the corporation's or institution's assets;

(ix) requirements for prospective accumulation of funds or current payments for construction, replacements, major modernization, or expansion of plant, equipment, and services, for which a certificate of need has been granted, and debt amortization of these projects in those years when the expenditures for those projects exceed the sum of depreciation payments under clauses (vii) and (viii), provided that the corporation or institution makes assurances to the State health commission that the total payments for these financial requirements over the life of the facilities will not exceed their general price level depreciation charges;

(x) requirements for a return (including but at no less a rate than the interest on debt capital) on total assets employed in the provision of institutional health services, with the Secretary determining annually a reasonable rate after consideration of rates of return on investments of comparable risk, and with such rate of return being included as a factor in developing prospective rates in the case of investor-owned institutions, or serving as a basis for developing amounts that will be included in determining the prospective rate or amount for not-for-profit providers in order to give appropriate recognition to the risk assumed under a prospective payment method;

(xi) provisions to assure that grants, gifts, and income from endowments and income earned on grants, gifts, and income from endowments will not be deducted from operating costs when computing reimbursable costs, except that—

(I) if the grant, gift, or endowment income was designated by the donor for paying or subsidizing specific operating costs, it may be deducted from the particular operating costs specified by the donor; and

(II) if the grant, gift, or endowment income was not restricted as to its use and is commingled with other funds, the income from the investment of the grant, gift, or endowment income may be deducted from the interest expense when computing reimbursable costs, but only to the extent that interest expense is not exceeded; and

(xii) provisions to assure that grants, gifts, and income from endowments and income earned on grants, gifts, and income from endowments will not be utilized for facilities or services which have not been granted a certificate of need as provided for in section 236(a)(7); and

(B) for individual providers or groups of providers, all reasonable fees, salaries, or other compensation for needed professional and related services;

(3) standards of quality and standards of safety for all facilities of, and all services furnished by, Health Care Corporations (including facilities of, and services furnished by, affiliated providers or other providers acting under arrangements with such corporations) and other providers; such standards to require, as a minimum, that hospitals, skilled nursing facilities, and home health agencies (including units of Health Care Corporations performing the functions of any such institutions) meet the applicable statutory requirements, pertaining to quality and safety, contained in title XVIII of the Social Security Act, and that other nursing homes meet such of the foregoing requirements as the Secretary finds appropriate;

(4) standards relating to the use of allied health professionals as assistants to physicians and dentists, and relating to the qualifications of such personnel;

(5) standards for the determination of qualified carriers under section 132;

(6) standards relating to confidentiality of information, including standards protecting the rights of patients to the confidentiality of information concerning their clinical and financial status, and permitting disclosure of such information only as specifically authorized by regulations of the Secretary and then only to the extent needed for purposes directly related to the administration of the program;

(7) consistent with section 212 (b) (2) and after consultation with providers of services and organizations of such providers, carriers, and other interested parties and organizations, standards for the development by State Health Commissions of prospective payment methods, including (A) review of the provider's budget and its proposed charges (including review and examination of other data and such inspection as may be deemed appropriate) ; (B) negotiations between the provider and the appropriate carrier or carriers within the State acting on their own behalf and the Secretary's; (C) a system of target rates for groups of providers; (D) a

formula approach based on factors such as cost per admission; and (E) other appropriate methods.

NATIONAL HEALTH SERVICES ADVISORY COUNCIL

SEC. 213. (a) There is hereby established a National Health Services Advisory Council (hereinafter in this section referred to as the "Council"), which shall consist of the Secretary, who shall serve as Chairman of the Council, and twenty members, not otherwise in the employ of the United States, appointed by the Secretary, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall include persons who are representative of providers of health services, and of persons (who shall constitute not less than one-half of the Council) who are representative of consumers of such services. Each appointed member shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of the members first taking office shall expire, as designated by the Secretary at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and five at the end of the fourth year, after the date of the enactment of this Act. Members of the Council who are representative of providers of health care shall be persons who are outstanding in fields related to medical, paramedical, hospital, or other health activities, or who are representative of organizations or associations of professional health personnel; and members who are representative of consumers of such care shall be persons, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the furnishing of such services.

(b) The Council is authorized to appoint such professional or technical committees, from its own members or from other persons or both, as may be useful in carrying out its functions. The Council, its members, and its committees shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Secretary for carrying out their respective functions. The Council shall meet as frequently as the Secretary deems necessary, but not less than four times each year. Upon request by seven or more members it shall be the duty of the Chairman to call a meeting of the Council.

(c) It shall be the function of the Council (1) to advise the Secretary on matters of general policy in the administration of this title and in the formulation of regulations (including prior review of and comment on such regulations, upon their issuance and upon any subsequent changes therein, before the publication of such regulations or changes in the Federal Register), and (2) to study the operation of this title and the activities of State Health Commissions, Health Care Corporations, and other providers, with a view to recommending any changes in the administration of this title or in its provisions which may appear desirable. The Council shall make an annual report to the Secretary on the performance of its functions, and the Secretary shall transmit the report to the Congress, together with a report by the Secertary on any administrative recommendations of the Council which have not been followed, and a report by the Secretary of his views with respect to any legislative recommendations of the Council.

(d) Appointed members of the Council and members of technical or professional committees, while serving on business of the Council (inclusive of traveltime), shall receive compensation at rates fixed by the Secretary but not exceeding the daily equivalent of the rate specified at the time of such service for grade GS–18 of the General Schedule; and while so serving away from their places of residence they shall be entitled to receive actual and necessary traveling expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b) of title 5, United States Code, for persons in the government service employed intermittently.

STUDIES OF DELIVERY AND FINANCING OF HEALTH CARE

SEC. 214. (a) The Secretary shall make a continuing study of the operation of this title, including the adequacy, quality, and utilization of services furnished by Health Care Corporations and other providers, the effectiveness of peer review and cost controls, the effectiveness of supervision of such corporations by State Health Commissions, the financing of services through insurance and otherwise, and all other aspects of the system of health care created pursuant to this title. The Secretary is authorized, also, to make studies and conduct research in regard to alternative methods of furnishing and financing health care (including methods followed in other countries), and of methods of enhancing, through financial incentives or otherwise, the quality of care and the economy and efficiency of its delivery.

(b) The Secretary may carry out his functions under this section directly or through contracts, and he is authorized to make grants to public or other nonprofit agencies or institutions for studies and research which he deems likely to further the purposes of this section.

(c) The Secretary shall from time to time publish the results of studies and research conducted pursuant to this section.

UTILIZATION OF STATE AGENCIES

SEC. 215. (a) The Secretary may, and to the optimum extent determined by him to promote efficient administration of this title shall, make arrangements with State Health Commissions (in accordance with section 234 (b) (9)) whereby the commission involved (directly or through arrangements approved by the Secretary with another State agency or agencies) will—

(1) subject to the applicable provisions of part C of title I, contract, as agent and in the name of the Department of Health, with carriers approved by the Secretary, as provided in paragraphs (1) (B) and (C) of section 217 (b) ; and

(2) from time to time perform such other functions for or on behalf of the Secretary, other than the issuance of Federal regulations and standards, under this title as the Secretary may deem appropriate.

(b) The Secretary shall, in accordance with section 220, pay State health commissions the cost of the proper and efficient administration of their functions under arrangements made with them pursuant to subsection (a).

FEDERAL FINANCING RESPONSIBILITIES FOR HEALTH SERVICES

SEC. 216. (a) Notwithstanding any provision to the contrary in title XVIII of the Social Security Act or in any other law, effective with respect to items and services furnished (and periods occurring) on or after the first transitional effective date as specified in section 301(b) and before the effective date for full operation of the program under this Act as specified in section 302—

(1) every individual who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act shall be automatically enrolled in the supplementary medical insurance program established by part B of such title (with such coverage period, and subject to such other terms and conditions, as may be prescribed by the Secretary in regulations);

(2) every resident of the United States who is a low-income person or a member of a low-income family (as those terms are defined in section 103(a)(1) of this Act), and who is not otherwise entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act or enrolled in the supplementary medical insurance program established by part B of such title, shall, under regulations prescribed by the Secretary (but without regard to age, insured status, or any other eligibility requirements, or any coinsurance, copayment, or deductible requirements, which might otherwise apply), be provided by the Secretary, from the Federal Hospital Insurance Trust Fund and the Federal Supple-

mentary Medical Insurance Trust Fund (as may be appropriate), with benefits under this Act equivalent to the hospital insurance benefits available under part A of title XVIII of the Social Security Act and the supplementary medical insurance benefits under part B of such title; and

(3) no premium or similar amount shall be payable by any individual for or on account of his enrollment in or coverage under the insurance program established by part B of such title XVIII, or for or on account of the provision to him of benefits under paragraph (2) of this subsection.

There are authorized to be appropriated from time to time to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate) sums equal to (A) the cost of the additional benefits paid from such funds by reason of paragraph (2), and (B) the total premiums which, but for paragraph (3), would be payable by all individuals for or on account of enrollment in or coverage under the insurance program established by part B of such title XVIII or the benefits provided to them under paragraph (2).

(b) Effective with respect to items and services furnished (and periods occurring) on or after the second transitional effective date as specified in section 301 (c) and before the effective date for full operation of the program under this Act as specified in section 302—

(1) every individual described in paragraph (1) or (2) of subsection (a) shall be provided by the Secretary (in addition to the benefits provided such individual under subsection (a)) with catastrophic expense benefits coverage under and in accordance with section 125 of this Act;

(2) every resident of the United States who is a medically indigent person or a member of a medically indigent family (as such terms are defined in section 103 (a) (2) of this Act), and who is not otherwise entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act or enrolled in the supplementary medical insurance program established by part B of such title, shall, under regulations prescribed by the Secretary (but without regard to age, insured status, or any other eligibility requirements which might otherwise apply), be provided by the Secretary, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate), with benefits under this Act equivalent to the hospital insurance benefits available under part A of title XVIII of the Social Security Act and the supplementary medical insurance benefits

available under part B of such title, and in addition shall be provided with Catastrophic Expense Benefits coverage under and in accordance with section 125 of this Act at premium rates determined under section 106; and

(3) any other individual who registers with a Health Care Corporation shall be entitled to the 10-percent premium subsidy under section 102 (c).

There are authorized to be appropriated from time to time to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate) sums equal to the additional costs incurred by such Funds by reason of benefits under this subsection.

(c) There are authorized to be appropriated for each fiscal year beginning on or after the effective date specified in section 302, for the purpose of financing the program set forth in title I of this Act, an amount sufficient to pay (on the basis of estimates for such fiscal year)—

(1) the cost of providing prepaid coverage for Comprehensive Health Care Benefits to persons who are under the age of 65 and are low-income persons or members of low-income families;

(2) the net cost, after deducting the contribution to be required of them, of providing such coverage to

persons who are under the age of 65 and are medically indigent persons or members of medically indigent families;

(3) (i) the added cost, resulting from their low incomes or their medical indigence, of providing such coverage to persons who have attained the age of 65 years and who either are low-income persons or members of low-income families or are medically indigent persons or members of medically indigent families, and (ii) the added cost of Comprehensive Health Care Benefits available to those eligible for benefits under part A of title XVIII of the Social Security Act;

(4) the cost of providing the 10-percent premium subsidy under section 102(c) for all individuals who register with Health Care Corporations and purchase Comprehensive Health Care Benefits privately (or for whom such benefits are purchased by private sources);

(5) the cost of health benefits provided for individuals receiving unemployment compensation benefits, and for members of their families, as described in section 906 of the Social Security Act;

(6) the cost of establishing or maintaining a reserve equal to 5 percent of the foregoing costs; and

(7) the cost of administration incurred by the Secretary in providing these coverages.

(d) For each fiscal year the Secretary shall estimate the costs referred to in subsections (a), (b), and (c) by projection based upon the costs in the second preceding fiscal year, or (in the case of the first two fiscal years involved) upon the Secretary's estimate of the costs that would have been incurred in such second preceding fiscal year if this title had then been in effect. Each projection shall take account of the then current rate of change in the cost of health services, expected changes in the low-income population and the medically indigent population, trends in the utilization of health services, and other factors which the Secretary finds relevant; and, in projecting aggregate contributions to be made by medically indigent persons and families, shall take account of the then current rate of change in the Consumer Price Index.

CONTRACTING AUTHORITY OF THE SECRETARY

SEC. 217. (a) (1) The Secretary shall, through contracts with carriers, provide the prepaid coverage for the benefits to which aged, low-income, and certain other individuals and their families are entitled under section 102.

(2) In addition to the qualifying requirements for carriers specifically set forth in this title, the Secretary may establish further qualifying standards for carriers (or classes thereof).

(b) (1) The Secretary may negotiate and enter into (A) contracts with a carrier or carriers to administer Comprehensive Health Care Benefits for all individuals entitled to benefits under section 102; (B) contracts with qualified carriers which have underwritten a prepayment plan for a Health Care Corporation operating wholly or primarily on a predetermined capitation charge basis; and (C) direct contracts with Health Care Corporations under section 135 if the corporations operate on a predetermined capitation charge basis and as such qualify as carriers.

(2) The Secretary may authorize State Health Commissions to act as his agents in contracting with carriers as described in paragraph (1).

(3) Contracts under this part are exempted from any provision of law requiring competitive bidding and from such other requirements of law as the Secretary may waive. The Secretary is required, however, to notify all potentially qualified carriers a description of the contract requirements he desires and the requirements and provisions of this title and regulations, and to invite these carriers to submit proposals. Among the factors which the Secretary is required under this title to consider in negotiating and approving contracts shall be the carriers' experience with group health insurance or prepayment plan coverage. The Secretary may require the contracting carrier to subcontract with other carriers, and he

shall enter into a contract with a combination of carriers only if this does not result in higher administrative costs and only if it best serves the purposes of this title. The term "combination of carriers" or "combination", as used in this section, means (i) a group of qualified carriers that have entered into a joint venture or other cooperative arrangement for the purpose of administering coverage under a contract under this part, or (ii) a corporation (which itself is a qualified carrier) designated or caused to be created by a group of qualified carriers for the purpose stated in clause (i) ; and any further reference in this part to a "carrier" shall be deemed to include reference to such a combination.

FEDERAL RESPONSIBILITY FOR DEVELOPMENTAL GRANTS

SEC. 218. (a) It is one of the purposes of this part to establish the responsibility of the Secretary to encourage, promote, and assist the establishment, as soon as practicable, of the comprehensive health care delivery system contemplated by this title, by providing financial and technical assistance for the early planning, development, establishment, and initial operation of Health Care Corporations, including incentives for use of the capitation payment method for health care, for the development and improvement of outpatient care centers, particularly in poverty and rural areas, and for the development of home health care agencies.

(b) There are authorized by the Secretary to be appropriated for each fiscal year, for carrying out the purpose stated in subsection (a), such sums as may be necessary. Sums so appropriated for grants or contracts for any fiscal year shall remain available for obligation until the close of the succeeding fiscal year.

AUTHORIZATION OF DEVELOPMENTAL FINANCIAL ASSISTANCE

SEC. 219. (a) For the purpose stated in section 218, the Secretary is authorized, in accordance with the provisions of this part, to make—

(1) grants for planning, organizing, developing, and establishing Health Care Corporations (or for any one or more of such activities), including affiliation or other arrangements (if any) of such a corporation with providers of health care, in conformity with part D of this title;

(2) contracts, in connection with the establishment or substantial expansion of Health Care Corporations, to pay for a reasonable period all or part of any operating deficits of such corporations;

(3) grants to Health Care Corporations, or to public or nonprofit providers affiliated therewith, for the initial operation of (A) new outpatient care centers, (B) new or expanded services in (or based in) out-

patient care centers, or (C) new or expanded home health care agencies; and

(4) grants for major health-maintenance, diagnostic, or therapeutic equipment, data processing systems or equipment, or central-service equipment, needed for initial operating capability of Health Care Corporations.

(b) (1) In making grants and contracts under this part, the Secretary (A) shall take into account existing health care resources and health care delivery systems in the several States, the relative need of the States and areas within the States for such assistance, and their populations, and (B) shall have due regard to the achievement, consistently with the purpose of this title and this part, of an equitable distribution of such assistance.

(2) Not more than 15 percent of the appropriations made for grants or contracts under this part may be expended in one State.

(3) In making grants and awarding contracts during the first five fiscal years for which funds have been appropriated under this part, the Secretary shall give priority to the applications of corporations that (A) operate primarily on the basis of predetermined capitation charges, or (B) are in the process of converting to primarily that basis, or (C) agree to operate on or convert to primarily that basis if awarded such a grant or contract. After that period, the

Secretary may award such grants and contracts only to such corporations.

(4) (A) A grant or contract shall not be made or awarded under the preceding provisions of this part when there is in effect, for the State that includes the area involved in the application for such assistance, a State plan approved under part C, unless the State Health Commission has recommended approval of the application and has certified—

(1) in the case of an application for a grant under subsection (a) (1) of this section, that there is need for a Health Care Corporation in the area involved (or of an additional Health Care Corporation if one approved under part C has already been assigned to the area);

(2) in the case of an application for a contract under subsection (a) (2) of this section or section 221, that the applicant (A) is a Health Care Corporation in conformity with section 241 (a), and (B) has been approved, or upon the Secretary's approval of the application for the contract will be approved, by the Commission under part D; or

(3) in the case of an application for a grant under subsection (a) (3) or (a) (4), that (A) the Health Care Corporation which is the applicant or involved in the application is in conformity with section 241 (a) and has been, or upon approval of the grant application by

the Secretary will be, approved by the Commission under part C; and (B) the outpatient care center or services thereof, the home health care agency, or the equipment or system, for which the grant is sought, is needed for the effective discharge of the corporation's functions under the State plan.

(c) (1) In the case of a State for which there is not yet in effect a State plan approved by the Secretary under part C but in which a State Health Commission and a State Advisory Council have been established in conformity with that part, the Secretary shall not make a grant or contract under the foregoing sections of this part unless the Commission, the State planning agency (if any) designated or established for the State as required under section 314 (a) (2) (A) of the Public Health Service Act (if it is a separate agency from the commission), and the appropriate areawide health planning agency (if it is different from the State planning agency) have had an opportunity (in accordance with regulations of the Secretary) to review and comment on the application for the grant or contract.

GRANTS FOR STATE PLANS

SEC. 220. (a) In order to facilitate and expedite the submission of State plans to the Secretary pursuant to section 234, the Secretary is authorized to make grants to State Health Commissions for all or part of the necessary cost of developing and preparing such plans, including (but not limited to) the expenses of their State advisory councils consulted in connection therewith, the cost of disseminating to the public and to others information concerning a proposed plan, and the cost of public hearings thereon.

(b) There are authorized to be appropriated for grants under this section such sums as may be necessary for each fiscal year in the period beginning with the fiscal year in which this Act is enacted and ending with the close of the third full fiscal year after this Act is enacted.

(c) (1) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title an amount equal to the Federal percentage of the sums expended for the proper and efficient administration of the State plan. Such payments and payments under grants pursuant to this section may be made in installments (not less often than quarterly) and may be made in advance (on the basis of estimates) or by way of reimbursement, with necessary adjustments on account of prior overpayments or underpayments.

(2) The Federal percentage, for the purpose of paragraph (1), shall be 90 percent with respect to sums expended by a State during fiscal years ending prior to the effective date of the benefit program under this Act (as set forth in sections 101 and 102), 85 percent with respect to

sums so expended during the next two fiscal years, and 75 percent with respect to sums expended thereafter; except that with respect to sums expended by the State for proper and efficient administration pursuant to provisions of the State plan contained therein in compliance with section 234 (b) (10) the Federal percentage shall always be 100 percent.

FINANCIAL ASSISTANCE UNDER OTHER PROGRAMS

Sec. 221. (a) (1) In administering other programs of financial assistance in the field of health care (including construction of facilities for health care) the Secretary and, on recommendation of the Secretary, other Federal agencies shall to the optimum extent utilize those programs to promote the purposes of this Act.

(2) Notwithstanding any other provision of law, the Secretary may, and such other agencies when requested by the Secretary shall, in the administration of such other programs, give (or require agencies and organizations assisted to give) highest priority to the needs of Health Care Corporations, particularly in areas determined by the Secretary to be urban or rural poverty areas.

(b) (1) The Secretary shall prepare and widely disseminate, through publications and otherwise, information concerning the availability of assistance under this part.

(2) The Secretary may upon request provide advice, counsel, and technical assistance to Health Care Corpora-

tions and other interested organizations and agencies in preparing applications, and in meeting the requirements of this part and of the Secretary, for grants and contracts authorized by this part.

PENALTIES FOR FRAUD

SEC. 222. (a) Any individual, provider of health care, carrier, or other person who—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit, or any grant or other payment, under this Act,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his or its initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other person in whose behalf he or it has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for a particular use or purpose and having received it, knowingly and willfully converts such benefit or payment or any part thereof to any other use or purpose,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Any provider of health care or other person who furnishes items or services to an individual for which payment is or may be made under this Act and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any organization, institution, or facility in order that it may qualify as a carrier or a provider of health care for purposes of this Act shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both.

PART C—STATE FUNCTIONS

GENERAL CONDITIONS OF STATE PARTICIPATION

SEC. 231. (a) States will be in compliance with this Act if, and only if, in conformity with the requirements of this part, (1) the State (A) has accepted the provisions of this Act and created, as a newly constituted and independent establishment within the executive branch of the State government, a State agency for carrying out the responsibilities devolving upon the State under this Act headed by a multimember governing body hereinafter in this title referred to as the "State Health Commission" (or as the "State commission" or the "commission"), and (B) has vested in such agency the exclusive authority on behalf of the State to establish and maintain appropriate standards and requirements for all hospitals, nursing facilities, and other institutional health care facilities in the State and to provide for the licensing of such facilities; (2) there has been established in that agency a State Advisory Council; and (3) there is in effect an approval, by the Secretary, of a State plan submitted by the State Health Commission under section 234 for carrying out the State's responsibilities under this title.

(b) For Federal exercise of State functions in cases of noncompliance by States, see section 238.

STATE HEALTH COMMISSIONS

SEC. 232. (a) The State Health Commission of a State shall be composed of three or five members (whichever number may be authorized under the law of its creation) appointed by the Governor of the State for staggered terms, which shall be renewable. Each term shall be for six years, except as necessary in the case of initial appointments to meet the requirement of staggered terms, and except in the case of a member appointed to fill a vacancy occurring before the expiration of the term of his predecessor. Not more than two members of a three-member commission, nor three members of a five-member commission, shall be members of the same political party. The Governor shall designate one of the members of the commission to serve as chairman.

(b) (1) It is the sense of the Congress that the members of a State Health Commission should be chosen, not primarily from the standpoint of specialized experience in the subject-matter fields within the commission's jurisdiction, but rather with a view to their ability to bring to the affairs of the commission broad gaged, highly qualified, effective, and disinterested policy direction. Persons representative of the health care providers shall not constitute a majority of the membership of the commission.

(2) During his term of membership, no member of the commission shall engage in any other business, vocation, or employment.

(3) The chairman and other members of the commission shall receive salaries at levels comparable to the compensation of the head of a principal executive department of the State.

(4) No member of the commission shall during his term of office be subject to removal except for dereliction of duty, corruption, incompetency, or conviction of a crime involving moral turpitude, or for a cause stated in paragraph (5) of this subsection.

(5) Any individual, while in the employ of or holding any official or contractual relation to or affiliation with a Health Care Corporation or any other corporation or provider of health care under the regulatory jurisdiction of the State commission, while in any manner pecuniarily interested in any such corporation or provider, shall be disqualified from being a member, officer, or employee of the commission; except that if such disqualification by reason of pecuniary interest arises otherwise than voluntarily while such individual is such a member, officer, or employee, the individual may be permitted to remain in office or employ-

ment if within a reasonable time he divests himself of that pecuniary interest. The preceding sentence shall not apply to membership on the State Advisory Council by an individual who discloses his interest in or relation to a corporation or provider, nor shall it apply to any individual solely because he is a registrant of a Health Care Corporation or a beneficiary member of or subscriber to another provider of health care.

STATE ADVISORY COUNCILS

Sec. 233. The Advisory Council to the State Health Commission of a State, which shall consult with the commission in the development and carrying out of the State plan, shall be appointed by the Governor of the State and consist of (1) persons broadly representative of health care providers (including health organizations) in the State (including but not limited to persons representative of Health Care Corporations when organized and approved, hospitals and other health care institutions, other nongovernmental and public organizations, societies and groups of health professionals, and schools and institutions particularly concerned with education or training of persons in the health professions and ancillary occupations), and (2) not less than an equal number of persons who are representative of consumers of health care and (A) neither are providers nor have a pecuniary interest in the provision of such care, (B) are familiar with the needs of the various segments of the State's population for such care, and (C) are experienced in dealing with problems associated with the provision of such care.

STATE HEALTH CARE PLANS

SEC. 234. (a) In order to be approvable under this part for any year the State plan of any State must—

(1) meet the requirements of subsection (b);

(2) have been submitted to the Secretary by the State Health Commission (constituted and operating in conformity with the preceding sections of this part) at such time and presented in such detail, and contain or be accompanied by such information, as the Secretary deems necessary;

(3) have been prepared in consultation with the State Advisory Council; and

(4) have been submitted to the Secretary only after the commission has afforded to the general public of the State a reasonable opportunity for presentation of views on the plan in the case of submission of the plan for initial approval or for annual renewal of approval after major revision of the plan.

(b) The State plan must—

(1) designate the State Health Commission of the submitting State as the sole agency for the administration of the plan, except as otherwise authorized by this part;

(2) contain or be supported by satisfactory evidence that the commission has the authority to carry out the plan in accordance with this part;

(3) provide for adequate consultation with the State Advisory Council in carrying out the plan;

(4) set forth, in such detail as the Secretary may prescribe, the qualifications for personnel having responsibilities in the administration of the plan;

(5) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan, including (A) methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208 (a) of the Intergovernmental Personnel Act of 1970 (Public Law 91-648), and (B) provision for utilization of qualified professional medical personnel (particularly in connection with the development or administration of standards of quality and utilization of health care) and of allied health professionals and other qualified professional staff; but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis

established and maintained in conformity with this paragraph;

(6) (A) provide for the designation of preferred service areas by applicant Health Care Corporations in accordance with the requirements of section 245 and for approval in each such area of one or more Health Care Corporations in accordance with section 235;

(B) include, with respect to existing and proposed Health Care Corporations, their affiliated providers of health care, and other such providers, (i) provisions incorporating the requirements of part D of this title, and (ii) the provisions required by section 236;

(C) provide, in accordance with sections 235 and 236, for cooperation with other States in the administration of the plan, and in particular authorize cooperative arrangements with adjoining States with respect to (i) joint service areas and (ii) establishment, admission, and approval of Health Care Corporations for service in such joint areas or for serving separate areas in the cooperating States; and

(D) include a program for completing (i) the initial approval of Health Care Corporations for service in designated areas (including, if necessary to carry out the purpose stated in section 2 (c) (2), the creation of governmental Health Care Corporations), and (ii) the initial registration of eligible individuals with such approved corporations, not later than the close of the fourth fiscal year that begins after the calendar year in which this Act is enacted;

(7) (A) include such provisions for effective arrangements or procedures as will assure an opportunity to obtain group coverage for Comprehensive Health Care Benefits at reasonable rates, for themselves or their employees, to all residents of the State who are not entitled to coverage of such benefits purchased by the Secretary, and provide for the effective enforcement of these arrangements and procedures by the commission (subject to review by the Secretary with respect to enforcement of Federal regulations);

(B) provide for regulating the premium rates of carriers issuing group health benefit prepayment plans or insurance contracts for residents of the State (except under contracts negotiated and made directly by the Secretary), except that the plan may—

(i) vest in the State agency primarily charged by State law with regulating the business of insurance in the State, or

(ii) authorize the commission to delegate to that or another appropriate State agency,

the function of regulating the premium rates for such prepayment plans or insurance contracts charged by carriers (other than Health Care Corporations acting as carriers for their own registrants);

(C) provide, consistently with regulations and standards of the Secretary relating to Comprehensive Health Care Benefits coverage, for the regulation and supervision of such carriers and such plans and contracts by the commission, including in the case of group coverage for Comprehensive Health Care Benefits the establishment, by the commission, of required standard provisions whereby, in the event of interruption or termination (by death or otherwise) of a covered individual's status as a member of the employee or other group that the plan or contract covers, the individual (or covered members of his family in case of his death) will have the privilege of continuing coverage under the plan or contract for a specified period (not less than 30 days) that the commission deems reasonable; and

(D) provide (subject to any regulation by the Secretary or interpretations thereunder with respect to contracts with carriers or otherwise with respect to coverage for Comprehensive Health Care Benefits)—

(i) for granting an opportunity for a fair hearing, before the commission, to any approved Health Care Corporation or nonaffiliated provider whose claim against a carrier for payment of charges for services or items furnished to a registrant of the corporation or a nonregistrant covered by the carrier for Comprehensive Health Care Benefits, or for payment of capitation charges with respect to a thus covered registrant in the case of a Health Care Corporation or other comprehensive health care delivery organization operating on a capitation charge basis, has been denied by the carrier in whole or in part, and

(ii) for adjudicating the claim;

(8) provide effective methods and procedures for (A) optimum utilization or adaptation, in the administration of the plan submitted under this section, of (i) such plans as have been or will be developed for the State pursuant to subsection (a) of section 314 of the Public Health Service Act, (ii) the State plan approved under subsection (d) of that section, (iii) any comprehensive plans developed under subsection (b) of that section for regions, metropolitan areas, or other local areas wholly or partly within the State, and (iv) relevant plans developed under any other programs, and (B) coordination (or, at the State's option, consolidation in the case of planning at State level) of planning under the plan submitted

under this section with ongoing or projected planning activities under those subsections or programs;

(9) provide that, if and to the extent requested by the Secretary, the commission (directly or through appropriate arrangements, approved by the Secretary, with another appropriate State agency or agencies) will perform, for or on behalf of the Secretary, any or all of the following functions:

(A) as authorized by section 215, contract, as agent of the Secretary, with qualified carriers for Comprehensive Health Care Benefits coverage in the State required under this Act to be financed by Federal purchase of such coverage from a carrier;

(B) act as fiscal agent of the Secretary in transactions with carriers (or classes thereof) in the State, including (if and to the extent that the Secretary assumes this function) the collection or receipt, and transmitted to carriers, of premium contributions by beneficiaries of federally purchased Comprehensive Health Care Benefits coverage (or by others on their behalf) when such contributions are required by or pursuant to this Act;

(C) furnish to the Secretary such timely information and prospective estimates as the Secretary may find necessary for developing its estimates of costs and required Government contributions under section 216;

(D) review, and make recommendations with respect to, applications to the Secretary for grants under appropriate sections of part B of this title, and, when requested, review and make recommendations with respect to applications to the Secretary for grants or contracts under other provisions of law administered by the Secretary, act as agent for the Secretary in investigating and certifying compliance with the terms and conditions of such grants or contracts, and make payments from Federal funds thereunder; and

(E) perform such other functions for or on behalf of the Secretary as he may reasonably request;

(10) develop and implement, after appropriate consultation with health care providers and consistent with the regulations of the Secretary, a system or systems of uniform accounting, reporting, and billing to be utilized by providers, carriers, and the commission within the State;

(11) (A) consistent with section 212(b) (6), in cooperation with the Secretary, and in accordance with such methods as may be recommended for the design and implementation of a nationwide cooperative

system for producing comparable and uniform health-related information and statistics, function as a center, for the State, for the collection (from Health Care Corporations and other providers, health benefit prepayment plans and private health insurance companies, and other sources), retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, including data on the fiscal operations of such corporations, plans, and companies and including data of the kinds enumerated in section 305 of the Public Health Service Act, and (B) require such corporations and providers, and such plans and companies doing business in the State, to make statistical and other reports of such information and data to the commission;

(12) consistent with section 212(b)(6), provide safeguards that restrict the purposes directly connected with the administration of the plan the use or disclosure of identifying information concerning (A) individuals with respect to whom information is obtained in carrying out the State plan provisions required by paragraph (11), or (B) individuals who are registrants or applicants for registration under this Act or who claim eligibility for Comprehensive Health Care Benefits coverage by a carrier;

(13) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the health-related and economic effectiveness of the activities of the commission and of Health Care Corporations (including their affiliated providers) and other providers under the commission's regulatory authority, including a review and comparative evaluation of data on utilization of health care services (including drugs) provided by Health Care Corporations and other providers;

(14) provide that the commission will make such annual and other reports (including reports of evaluations made pursuant to the provisions contained in the plan in accordance with the preceding paragraph) as the Secretary may from time to time reasonably require, and comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports; and

(15) provide that the commission will from time to time, and in any event not less often than annually, review the plan and submit to the Secretary any modification thereof which it considers necessary.

(c) The Secretary shall approve any State plan and any modification thereof which complies with subsections (a) and (b); except that he shall not grant such approval if the plan or modification or other State law (statutory or otherwise) or the practice of a State licensure or regulatory authority under color of law—

(1) prevents or limits Health Care Corporations (approved by the commission under the plan) or other health care institutions from undertaking to provide covered health care to registrants (and to others at its election) or patients (A) through direct employment of medical or other licensed health care practitioners by the corporation or other nonprofit providers, or (B) through prepaid group practice (as defined by regulations of the Secretary) or other arrangements by the corporation or other providers with such practitioners or groups thereof (whether such arrangements be on a capitation, fee-for-service, or other basis); or

(2) deprives any Health Care Corporation of its right to designate its preferred service area and of its right of appeal for change in such service areas, in accordance with the provisions of this Act; or

(3) disqualifies from service on the governing board of a Health Care Corporation or institutional provider thereof a physician who is on the staff of the Health Care Corporation or such provider or is an affiliated provider of the Health Care Corporation; or

(4) prevents or limits such practitioners from em-

ploying or arranging with appropriately trained assistants under their supervision to perform, consistently with standards of the Secretary prescribed under section 212 (b) (4), health care functions commensurate with their qualifications and training; or

(5) prevents or limits carriers from offering coverage of health care provided in accordance with paragraph (1), (2), (3), or (4),

unless the Secretary determines, in accordance with regulations issued by him, that the prohibition or restriction is consistent with the purposes of this title.

(d) (1) An approval of a State plan submitted to the Secretary under this part shall, unless renewed, or unless sooner withdrawn or suspended under this part, be in effect for a period of one calendar or fiscal year, whichever the Secretary determines, except that the initial approval may be for the remainder of the fiscal or calendar year then current or, where deemed appropriate by the Secretary, may be made effective until the end of the succeeding year.

(2) For the purposes of this Act, a State with respect to which there is in effect an approval of a State plan by the Secretary under this part, or with respect to which the Secretary is performing the functions that he is authorized to perform under section 238 (a) or (c) (4), is a "participating State".

DESIGNATION OF HEALTH CARE AREAS

SEC. 235. (a) As soon as practicable after its organization, the State Health Commission of each participating State shall conduct a study and survey with a view to the approval of service areas for applicant Health Care Corporations as a basis for the issuance of certificates of approval by the commission (in accordance with section 236(a)(3)), with the objective of affording to all the people in the State equal and ready access to the full range of comprehensive health care of high quality provided for in this title and, where practicable, a choice among Health Care Corporations. In making its study and survey, the commission shall give appropriate consideration to (1) the size and distribution of the State's population and the incidence of illness or disease in population groups in different regional, metropolitan, or other local areas (or parts thereof) of the State, (2) existing health care organizations, institutions, or resources for the provision of health care, their potential for sponsoring or participating in the organization of Health Care Corporations, and their distribution in relation to the need for care, (3) local governmental structures, (4) transportation facilities, (5) patterns of organization for the delivery of health care, (6) patterns of use of health care, and (7) other relevant factors. To assist in its study and survey, and especially in connection with its consideration, and evaluation of the factors referred to in clause (2) of the preceding sentence, the commission shall set a date by which shall be filed with its applications by Health Care Corporations for certificates of approval for operation in areas defined in the respective applications (or statements of intention, by proposed sponsors of such corporations, to file such applications). No such certificate shall be granted under section 236 until a final regulation has been issued under the last sentence of subsection (c) (1) of this section.

(b) In addition to making the study and survey referred to by subsection (a), and before approving applications for certificates of approval, the commission shall consult with persons representative of the general public, representatives of public and private hospitals and other health care institutions or their organizations, representatives of the medical and other health care professions, including persons representative of health care practitioners engaged or employed in prepaid group practice, representatives of appropriate State and local governmental agencies, State commissions in adjoining States (where appropriate), and other interested groups and individuals.

(c) (1) After its study, survey, and consultation, the commission shall publish a proposed regulation setting forth its findings and approvals of Health Care Corporations and the service areas proposed, which need not coincide with the areas of existing municipalities or political subdivisions of the State. The commission shall give reasonable public notice of its proposal and of a public hearing or hearings on the proposal and shall, after such hearing or hearings, by final order confirm the regulation or issue a revised regulation.

(2) In carrying out this section the commission may, in accordance with cooperative arrangements referred to in section 234(b)(6)(C), designate jointly with another State or States a service area or areas that include parts or all of such States.

(d) The commission may, either on its own motion or on petition of any interested Health Care Corporation or other interested provider of health care, an interested registrant or organization representing registrants, or any other interested person, amend or repeal a final regulation issued under subsection (c), but final action on a proposal under this subsection may (upon request of an interested person filing objections to the action proposed, specifying with particularity the changes desired, and stating reasonable grounds therefor) be taken only by decision on the record made after reasonable notice and opportunity for a fair hearing.

REGULATORY FUNCTIONS OF STATE HEALTH COMMISSIONS

SEC. 236. (a) For the purposes of part D of this title and of paragraph (6) of section 234(b), a State plan shall, in addition to complying with section 235—

(1) provide for (A) stimulating and encouraging the organization of Health Care Corporations (as defined in section 241(a)) where needed, by (i) giving information and advice to providers of health care and other potential sponsors as to the requirements for organization of such corporations and for commission approval of such corporations for service, (ii) giving technical assistance to sponsors in meeting such requirements, and (iii) in appropriate cases recommending to the Secretary grants or contracts under part A of this title; and (B) in accordance with cooperative arrangements referred to in section 234(b)(6), cooperating with State Health Commissions of other States in jointly (or concurrently) or reciprocally admitting and approving Health Care Corporations for service, especially in joint or adjoining service areas of the respective States;

(2) provide for authorizing the incorporation in the State, or admission from other States, of nonprofit corporations and, at the State's option, of governmental

corporations that can under the law of the State qualify as Health Care Corporations in accordance with section 241 (a), but this function may at the option of the State be vested in an authority of the State other than the State Health Commission if this will not substantially permit the duplication of functions of the commission or impede the objectives of this Act;

(3) (A) provide for evaluation of the application of any corporation (incorporated in or admitted to the State in accordance with paragraph (2)) for approval to operate as a Health Care Corporation in a service area or areas approved by the commission in accordance with section 235;

(B) provide for granting such approval (evidenced by a certificate of approval) if (after reasonable notice and opportunity for hearing to the applicant, to any other corporation which holds or has applied for a certificate of approval for the service area or areas involved, and to the public) the commission finds—

(i) that the applicant qualifies as a Health Care Corporation in conformity with section 241 (a) and satisfies the requirements of clauses (2) and (3) of section 241 (b),

(ii) that there is need for the facilities and services to be provided by the applicant in the area or areas covered by the certificate,

(iii) if another Health Care Corporation or corporations already holds a certificate of approval for a service area covered by the certificate, that the additional operation of the applicant in that area will be economically feasible and will promote the purpose of giving a choice to registrants as stated in section 2 (c) (2), and

(iv) if there is also pending before the commission the application of another Health Care Corporation for approval of its operation in a service area included in the certificate granted to the first-mentioned applicant, that in the review process the two applications have been jointly considered and either (I) that approval is also granted to the other applicant or (II) that for reasons stated in the commission's findings approval to the other applicant is denied; and

(C) provide that any certificate of approval granted by the commission is subject to revocation or amendment in accordance with subsection (c) of this section or upon revision of the approved service area or areas, covered by the certificate, under the provisions included in the State plan in accordance with section 235;

(4) provide, with respect to any service area for which more than one Health Care Corporation is approved and in which the combined capacity of all such

corporations is sufficient to serve adequately all residents of the area but in which the separate capacity of one or more (but less than all) of such corporations can serve adequately only a reasonable proportion of the area's residents, for allowing any such corporation (whose capacity is thus limited) to restrict to a number approved by the commission the number of individuals whom it will accept for registration, and requiring the corporation in that event to accept, in such manner as may be required by the commission, residents of the area up to that number for registration on a first-applied first-accepted basis; but the plan shall preclude any action or procedure under this paragraph that does not assure the adequate provision, on a nondiscriminatory basis, of all the benefits of this Act to all the residents of the area who desire to register;

(5) (A) provide for limiting all charges of approved Health Care Corporations and other licensed providers for health services and items to the kinds of charges and the rates that are prospectively approved by the commission. The commission, in accordance with the principles and requirements of sections 212 (b) (2), 212 (b) (7), and 246, and after consultation with providers of services and organizations of such providers, carriers, and other interested parties and organizations

shall develop and make available to providers of services one or more methods of obtaining payment on a prospective basis for services furnished under this Act, with such methods including budget review; negotiated rates; target rates; formulae; or any other method consistent with the regulations of the Secretary. Where more than one method is available, providers will have the option of electing to utilize any one of such prospective payment methods. Once a provider elects a particular method, it may not alter its election without prior approval of the commission. Where the commission finds that the number of providers electing a prospective payment method promulgated in accordance with this paragraph is not sufficient to provide an adequate basis for either the operation or evaluation of that method, or that method does not achieve improved results, then the commission shall withdraw that method and allow the electing providers to select another method within 30 days of notice of such withdrawal;

(B) require that the prospective rates established through the methods noted in subparagraph (A) do not (i) make provision for services that are excessive or unnecessarily duplicative, or (ii) take into account any actual or proposed capital expenditures (as defined in regulations of the Secretary) related to construction or rental of health care facilities by or for the provider for which the commission has not granted a certificate of need when required under the plan;

(C) require that charges for physicians' services, such as those of radiologists and pathologists, that are held out as generally available to all inpatients of an institution, be included as part of institutional-service charges and not as separate physicians' services charges (regardless of the method of payment to the physician);

(D) require that the provider's budgets, proposed charges, and other necessary reports be prepared in accordance with accounting principles, consistent with sections 212 (b) (1) and 234 (b) (10), designed to bring about uniform methods of determining institutional costs and financial requirements; and

(E) provide for granting an opportunity for a fair hearing to any health care provider which is dissatisfied with a decision of the commission with respect to the provider's proposed charges;

(6) provide for effective enforcement, by the commission, of the responsibility of approved Health Care Corporations and other licensed providers to (A) provide the necessary health care and items for which the registrants have Comprehensive Health Care Benefits coverage, (B) assure that such care be of not less than

the scope, quality, and comprehensiveness required by this Act, including regulations and standards of the Secretary prescribed under part B of this title, (C) in the instance of Health Care Corporations, perform the functions specified in sections 243 and 244 with respect to services furnished by others to registrants while absent from their place of residence or in emergencies, and (D) in the instance of nonaffiliated providers, perform functions similar to those specified in section 244, as specified in regulations;

(7) prohibit the construction, modernization, or expansion of facilities and services of hospitals, skilled nursing facilities, nursing homes, or other health care facilities, or the establishment of such facilities through rental of major equipment or existing structures, by Health Care Corporations or other providers, except when authorized by a certificate of need by the commission;

(8) authorize the commission in its discretion to adjudicate, at the request of an approved Health Care Corporation or a provider affiliated with it, or a nonaffiliated provider, a controversy between the corporation and the provider with respect to any matter within the regulatory or supervisory authority of the commission;

(9) provide for granting an opportunity for a fair

hearing before the commission (A) to any individual who is not accepted for registration by an approved Health Care Corporation of whose approved service area he claims to be a resident; or (B) with respect to a monetary claim by a registrant against a provider or against a carrier under whose prepayment plan the individual is covered for Comprehensive Health Care Benefits, or by a provider or a carrier against the individual relating to the provision of health care or to such coverage, where the claim has been denied (in whole or part) or is not acted upon with reasonable promptness and the amount in controversy is $100 or more; or (C) to any individual who alleges a substantial failure of the provider with respect to the provider's obligations to provide health care to the individual, and alleges facts showing that the failure is part of a pattern of similar conduct;

(10) provide for review and approval of peer review systems of approved Health Care Corporations and for continuous surveillance over the performance of approved Health Care Corporations in relation to their obligations under this Act, and enforcement of those obligations as provided for in this section; and

(11) provide for review and approval of peer review systems of nonaffiliated providers and for continu-

ous surveillance over the performance of such providers in relation to their obligations under this Act, and enforcement of those obligations as provided in this section.

(b) If a Health Care Corporation or nonaffiliated provider complies with the procedures set forth in sections 1863 through 1865 of the Social Security Act, such provider shall be deemed to meet the standards relating to comparable elements established by this Act and regulations thereunder.

(c) (1) (A) Whenever the State Health Commission determines that there is a failure on the part of an approved Health Care Corporation (whether owing to its own acts or omissions or those of a provider furnishing services on its behalf) to fulfill all obligations assumed by the corporation or placed upon it by this Act, the commission shall by order direct the corporation to take prompt corrective action.

(B) If the corporation, within such reasonable period as may be required by the commission by regulation, requests a hearing on the commission's order and states reasonable grounds for objecting to the decision, the commission shall give the corporation reasonable notice and opportunity for a hearing with respect to the commission's decision and, if a hearing is held, shall on the basis of the record at the hearing render a decision, subject to such judicial review on the record as may be provided by applicable State law. Initiation of a proceeding for judicial review shall not operate as a stay of the commission's decision unless so ordered by the court.

(2) Notwithstanding paragraph (1), where the failure of a Health Care Corporation to comply with its obligations is so gross as in the judgment of the commission to create an imminent hazard to the health of registrants, the commission may give its order immediate effect, subject to later reversal or modification if so determined after hearing or after judicial review.

(3) In addition to the authority of the commission to order corrective action to be taken as above provided, the State plan shall, in the event of a substantial failure of the corporation to fulfill its obligations, empower the commission, after reasonable opportunity for a fair hearing, (A) to revoke its certificate of approval for operation by the corporation and issue for the service area involved a certificate of approval to another Health Care Corporation, or corporations, or (B) in lieu of such revocation, to take effective action (through appointment of a receiver for the corporation or other appropriate means) to bring the corporation into compliance with its obligations and provide its registrants with the health care services to which they are entitled. The order of the commission shall, when final, be subject to judicial review in a State court of competent jurisdiction on the basis of the record before the commission,

and the findings of fact of the commission shall, if supported by substantial evidence in the record when considered as a whole, be binding on the court.

(d) The commission is authorized to take corrective action whenever it determines that any provider not affiliated with a Health Care Corporation has failed to fulfill the obligations set forth in this Act, this action to include suspension of payment for services performed under Comprehensive Health Care Benefits. The appeal procedures outlined in subsection (c) shall apply with respect to action taken under this subsection.

JUDICIAL REVIEW

SEC. 237. (a) Any State that is dissatisfied with a final action of the Secretary taken under section 238 (other than subsection (c) (3) thereof) may obtain judicial review of such action by filing, within sixty days after such action, a petition for review with the United States court of appeals for the circuit in which the State is located. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which it based its action, as provided in section 2112 of title 28, United States Code. Upon the filing of the petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record the Secretary may modify or set aside its order.

(b) The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

FEDERAL EXERCISE OF STATE FUNCTIONS IN CASES OF NONCOMPLIANCE BY STATES

SEC. 238. (a) In the case of any State which has not established a State Health Commission in conformity with section 232, and submitted to the Secretary an approvable

State plan pursuant to section 234, prior to the third fiscal year that begins after the calendar year in which this Act is enacted, the Secretary may, until such a State plan has been submitted to and approved by him under this title, assume and exercise, through the Department of Health, with respect to the area of that State, those functions which would be required or authorized by this title to be exercised by the State Health Commission of that State if there were in effect a State plan approved under this title, and may utilize for that purpose any funds available under this title for payments for the administration of State plans. In any case in which the Secretary invokes the authority contained in the preceding sentence, any State law or practice that under section 234 (c) would preclude approval of a State plan under this title shall be inoperative.

(b) (1) The Secretary shall not finally refuse to approve a State plan submitted to it under this title except after according to the State reasonable notice and opportunity for hearing.

(2) If, at the scheduled expiration of the effective period of approval of a State plan, there is pending before the Secretary an application of the State for renewal of the approval, the Secretary may, by order, temporarily postpone the scheduled expiration date until its decision on the application for renewal.

(c) (1) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Health Commission administering a State plan approved under section 234 (c), determines—

(A) (i) that the plan has been so changed that it no longer complies with the provisions of section 234 (b), including any provision of this title incorporated therein by reference, or (ii) that in the administration of the plan there is a failure to comply substantially with any such provision;

(B) that there is a failure to comply with any requirement of section 232; or

(C) that the State law or practice is such as, under the provisions of section 234 (c), would preclude approval of the plan;

the Secretary shall by order withdraw approval of the plan and withhold further payments under section 220 (c) (or, in the Secretary's discretion, suspend approval as to the part or parts of the plan affected by a failure determined under clause (A) or (B) of this paragraph and limit payments to those payable with respect to other parts), until the Secretary is satisfied that there will no longer be any such failure to comply or, in a case described in clause (C), until the plan is approvable under section 234 (c), and shall forthwith notify the commission of the order.

(2) If in the judgment of the Secretary it would better promote the purposes of this title to do so, he may postpone the effective date of his order under paragraph (1) for such reasonable period as he finds appropriate to allow necessary time for compliance with the requirements of this title.

(3) In addition to or in lieu of issuing an order pursuant to paragraph (1), the Secretary may request the Attorney General to institute a civil action by the United States against the State to enforce the requirements of this title.

(4) Whenever the Secretary has withdrawn approval of a State plan pursuant to paragraph (1), he may, with regard to the State involved, exercise the functions and use the funds referred to in subsection (a).

COOPERATIVE INTERSTATE ACTIVITIES AND UNIFORM LAWS

SEC. 239. (a) The Secretary (1) shall encourage and assist the States and their State Health Commissions in carrying out cooperatively with other States their respective functions in accordance with part C, including the making of agreements between States for that purpose with respect to the establishment, admission (into jurisdictions other than those of incorporation), and approval of Health Care Corporations, the establishment of joint health care areas and assignment of such corporations thereto, the exchange of information, and other matters, and (2) shall develop and encourage the enactment of model State legislation in the fields covered by this title.

(b) The consent of the Congress is hereby given to any two or more States to enter into agreements of the kinds referred to in subsection (a), not in conflict with any provision of this Act or regulation of the Secretary thereunder or with any other law or treaty of the United States.

OTHER ADMINISTRATIVE PROCEDURES

SEC. 240. (a) Effective on and after the effective date of part A of title I of this Act, the Secretary is authorized and directed, notwithstanding any provision of title V of the Social Security Act, to provide by regulation for limiting the use (directly or indirectly) of Federal funds under title V of the Social Security Act for personal health services and items (or for reimbursements for expenditures for such services or items) in participating States (as defined in section 234 (d) (2) of this Act) in such manner as will avoid to the maximum extent practicable the use of such funds for personal health services or items for individuals to the extent that these individuals are entitled under section 102 (b) of this Act to Comprehensive Health Care Benefits coverage for like services and items.

(b) (1) Section 505 (a) (2) of the Social Security Act is amended (A) by striking out "State health agency" the first time these words occur and inserting in lieu thereof

"State Health Commission (established in accordance with section 231 of the National Health Care Services Reorganization and Financing Act)", and (B) by striking out "State health agency" the second time these words occur and inserting in lieu thereof "State Health Commission".

(2) The amendments made by paragraph (1) shall, with respect to any State, become effective on the date on which the State becomes a participating State (as defined serting in lieu thereof "State Health Commission".

PART D—HEALTH CARE CORPORATIONS

INCORPORATION AND STATE APPROVAL

SEC. 241. (a) A Health Care Corporation is a nonprofit private or governmental corporation which (1) is organized for the purpose of furnishing (through its own facilities and personnel or through other providers, nonprofit or for-profit) comprehensive and coordinated personal health services to persons registered with the corporation, furnishing personal health services to other persons to the extent authorized by this title, and engaging in educational, research, and other activities related or incidental to the furnishing of personal health services; and (2) provides (or will provide after the period of organization and initial registration) effective and equitable representation, on its governing board, of the registrants with the corporation and of the affiliated institutional and professional providers furnishing services on its behalf.

(b) A Health Care Corporation is eligible, for the purposes of this title, to furnish services in a State only if it is approved by the State Health Commission of the State for operation in an approved service area or areas of the State (under the provisions of the State plan in accordance with sections 235 and 236), upon a finding by the commission (1) that the corporation conforms to the provisions of subsection (a), (2) that it has an adequate organization under professionally competent management and adequate resources in facilities and personnel (including resources available to it through contracts with affiliated providers), to meet the requirements of this part and of regulations prescribed thereunder and requirements prescribed by the State Health Commission, and (3) that it has given assurances (including assurances of financial responsibility), satisfactory to the commission, that in operation it will meet all such requirements.

REGISTRATION WITH HEALTH CARE CORPORATIONS

SEC. 242. (a) A Health Care Corporation shall, in accordance with regulations of the State Health Commission—

(1) register with the corporation all persons (or such number of persons as may be required by the commission pursuant to section 236(a)(4)), resident in the service area approved for it by the commission,

who apply for such registration during a period of open registration fixed by the commission, or apply therefor after termination of registration with another corporation pursuant to subsection (e);

(2) make all reasonable efforts, on a continuing basis, to procure the registration of persons resident in the area who, having failed to apply for registration, have been assigned by the commission to the corporation for recruitment; and

(3) within its capacity to furnish services, register with the corporation all persons assuming residency in the approved service area after the end of the period of open registration fixed under paragraph (1).

(b) Within its capacity to furnish services and with the approval of the commission, the corporation may recruit and register persons (whether or not residents of the area) whom it is not required by subsection (a) to recruit or register.

(c) In such cases and such manner as may be specified in regulations of the Secretary, a registrant may effect registration on behalf of his or her spouse and children under 19 years of age.

(d) The corporation shall make available, and shall employ all reasonable means to disseminate throughout its approved service area, full information about its operations, including descriptions of the services it furnishes and places where they are furnished, and including information about the methods and times of registration; and information about the benefit coverages (both those purchased by the Secretary and others) available to residents of the area, and the methods of obtaining such coverage. It shall assist registrants and applicants for registration to establish entitlement to coverage purchased by the Secretary under section 102, and to obtain other coverage as appropriate.

(e) Registration with a Health Care Corporation shall be effective for a period of twelve months, except that a registrant may terminate his registration if he changes his place of residence or for such other cause as may be approved by the State Health Commission.

UNDERTAKING TO FURNISH SERVICES

SEC. 243. (a) A Health Care Corporation shall assume responsibility for making available and furnishing to each registrant with the corporation, and to any other person to the extent required by regulations of the Secretary, all services for which he has Comprehensive Health Care Benefits coverage and which are medically necessary (or, in the case of health maintenance services, medically appropriate). The acceptance of a registration shall constitute an obligation of the corporation to the registrant to furnish all such services, either through the facilities and personnel of the corporation, through affiliated providers meeting the requirements of subsection (b), or through other providers in accordance with subsection (c).

(b) Services may be provided through an affiliated provider who, by contract with the Health Care Corporation, has undertaken (1) to furnish on behalf of the corporation a portion of the services for which the corporation is responsible, and (2) to cooperate and (to the extent practicable) participate in discharging all other responsibilities of the corporation under this part. Affiliated providers may be hospitals, skilled nursing facilities, nursing homes, or home health care agencies (hereafter referred to collectively as "institutional providers"); physicians, dentists, podiatrists, or optometrists; combinations of the foregoing, such as partnerships, clinics, or group practice organizations, which may include appropriate allied health professionals and technical or other supporting personnel; or other providers of kinds designated in regulations of the Secretary. The services of an affiliated provider may, but need not, be furnished exclusively on behalf of one Health Care Corporation. A provider may be affiliated with two or more Health Care Corporations, but in the case of an affiliated institutional provider shall designate one affiliation as the provider's primary affiliation for the purpose of maintaining quality of services, control over the utilization of services, and continuing appraisal of the effectiveness of services.

(c) Drugs, devices, appliances, and equipment may be furnished to outpatients and to home health care patients, and ambulance and other emergency transportation services may be furnished, through providers not affiliated with the corporation, under arrangements which the commission finds assure adequate availability of such items and services. Medical and other services of specialized nature, which the commission in accordance with regulations of the Secretary finds cannot practicably be furnished by a Health Care Corporation or its affiliated providers, may be furnished through arrangements with or referral to other Health Care Corporations or other providers.

(d) The organization of the services furnished by or on behalf of the corporation shall emphasize health maintenance (including health education) of registrants, assure continuity of care and referral of patients to such services and at such time as may be medically appropriate, and to the greatest extent possible provide care on an outpatient basis. All services shall be made as readily available as is practicable to all registrants within the approved service area of the corporation, and the corporation shall (in accordance with regulations of the Secretary) maintain a system of scheduling periodic health maintenance services for each registrant and reminding him thereof. Outpatient care shall be furnished in centers and physicians' offices conveniently accessible throughout the area. Emergency care, including ambulance service within the approved service area of the corporation, shall be available at all times.

(e) The corporation shall as rapidly as practicable develop, by affiliation with existing organizations or otherwise, a system of outpatient care centers throughout its approved service area, utilizing hospital medical staffs and other physicians practicing in the area, and staffing the centers with physicians, appropriate allied health professionals, and other ancillary personnel to furnish primary medical care. To the extent practicable, the corporation shall also furnish through or in conjunction with such centers health maintenance services and community-based services such as home care, medical social services, and the services of well-baby clinics and mental health clinics. Centers shall be so related to institutional or other providers as to assure the availability of necessary laboratory and other diagnostic services, and the ready referral and transfer of patients to facilities providing more comprehensive services when medically necessary or appropriate.

(f) Whenever services for which the corporation is responsible under subsection (a) are furnished by another Health Care Corporation to a registrant who is absent from his place of residence, or are furnished in an emergency by any provider (wherever situated) who is not affiliated with the corporation or acting under arrangements with it, the corporation shall review a report of the services rendered and the charge therefor and shall submit it to the carrier responsible for its payment; or, if it is itself the carrier or is otherwise responsible for payment, shall pay the charge. This subsection shall not be applicable in the case of a registrant who, otherwise than pursuant to arrangement by the corporation, has left his place of residence for the purpose of obtaining health services.

(g) The corporation shall so far as practicable furnish necessary emergency health services to persons not registered with it, and may furnish other services to such persons when it can do so without interference with services to its registrants.

QUALITY OF SERVICES

SEC. 244. (a) A Health Care Corporation shall assume responsibility (1) for the quality of all services furnished by it either through its own facilities and personnel or by providers affiliated or acting under arrangements with it, and for compliance with standards of quality and comprehensiveness prescribed by the Secretary, (2) for maintaining controls upon the utilization of all such services, (3) for continuing appraisal, through medical audits and otherwise, of the effectiveness of such services, and (4) for identifying problem areas requiring planning for additional services. For these purposes the corporation shall maintain a system (approved by the commission) of comprehensive peer review by a group or groups of physicians (and a group or groups of dentists in the case of dental services) selected from its staff and from affiliated providers and their staffs, embracing services furnished by affiliated providers as well as services furnished directly by the corporation, and shall require similar review by a staff committee or committees of each hospital and skilled nursing facility affiliated with it. The corporations shall, through an appropriate staff committee or committees, maintain a program of continuing professional education of physicians, dentists, and nurses (and, to the extent the corporation deems desirable, of other professional personnel) furnishing services on its behalf.

(b) All medical policies of the corporation shall be established with the advice of physicians, and all dental policies with the advice of dentists. All medical judgments related to health care shall be made by or under the supervision of physicians, and all dental judgments by or under the supervision of dentists.

(c) The corporation shall encourage the participation of physicians in all aspects of its policy-formulation and operation (including budget review and long-range planning), both in administrative and in advisory capacities.

PARTICIPATION OF PROFESSIONAL PRACTITIONERS

SEC. 245. (a) Within the limits of its need for physicians, dentists, podiatrists, and optometrists (hereafter referred to collectively as "practitioners"), and so far as is consistent with the furnishing of the highest practicable quality of care, a Health Care Corporation shall provide opportunity to all practitioners practicing in its approved service area to furnish services on its behalf, either (at the election of the corporation) as members of its professional staff or as affiliated providers. It shall fix, and review annually, the scope of services which each practitioner may so furnish, in accordance with his training, experience, and professional competence as determined, pursuant to rules of the corporation, through peer review of his credentials and performance. A practitioner who desires to enlarge the scope of services assigned him shall be assisted through in-service training in acquiring added experience and professional competence, and his assigned scope of service shall be reconsidered from time to time.

(b) In selecting practitioners to furnish services on its behalf and in fixing the scope of services which each may furnish, the corporation shall not discriminate on any ground unrelated to professional qualifications; but in carrying out the purpose of subsection (a) in its initial recruitment of practitioners the corporation may give preference, as between equally qualified persons, to those who at the time are practicing in its approved service area.

(c) The corporation shall so organize the services furnished by practitioners on its behalf as to meet the purposes of sections 243 and 244. To the extent consistent with such organization it shall permit each practitioner to elect the form or forms of practice (individual office practice, group practice, or other form of practice) in which he wishes to engage.

CHARGES BY HEALTH CARE CORPORATIONS AND OTHER PROVIDERS

SEC. 246. (a) All charges by a Health Care Corporation or other provider for health services shall be made at rates fixed by the corporation or other provider prospectively and approved by the commission. Rates applicable to a particular fiscal period may be revised before the end of the period only on the basis of events, occurring subsequent to the approval, which the commission finds (1) could not reasonably have been foreseen at the time of approval, and (2) will, if the rates are not revised, impose severe financial hardship on the corporation or other provider.

(b) Such charges shall consist either of an annual amount for each registrant or registrant family (hereafter referred to as a "capitation amount"), or of itemized charges for separate services or units of service. With the approval of the commission, the corporation or other provider may use one method of determining charges for some services or with respect to some registrants and the other method for other services or with respect to other registrants; except that after three years of operation a Health Care Corporation must submit to the State Health Commission a plan to commence two years thereafter for offering capitation rates to its registrants who choose to purchase coverage directly from the corporation. Except for reasonable variations (in accordance with regulations of the Secretary) based on the size and composition of families, capitation amounts shall be uniform for all registrants to whom they are applicable, other than registrants having coverage under contracts purchased by the Secretary.

(c) Charges of the corporation or other provider, by whichever method determined, shall be at rates estimated to be sufficient for the fiscal period to meet the financial requirements of the corporation or other provider, to enable it to fulfill its responsibilities under this part. The financial requirements shall be determined in accordance with regulations, and with systems of accounting, consistent with sections 212 (b) and 234 (b) (10).

(d) The corporation, other health care providers, and the commission, in developing and reviewing the rates to be paid to providers, shall seek to assure that adequate services are available without unnecessary duplication or other excessively costly or excessive services.

CONTINUING PERSONAL HEALTH RECORD

SEC. 247. (a) In a manner consistent with the requirements relating to confidentiality in subsection (d), a Health Care Corporation shall develop, and keep current, a continuing personal health record for each registrant of the corporation, in such form, consistent with regulations of the Secretary, as may be required by the commission for the purposes (1) of making medical histories and other pertinent data readily available to the medical and other staff of the corporation and its affiliated providers, and (2) of enabling the corporation to meet requirements of the commission for gathering and reporting health care statistics, including statistics on the utilization and cost of health services.

(b) The corporation shall, to the greatest extent practicable, equip its facilities, and assure that facilities of its affiliated providers are equipped, for the prompt transmission, to appropriate members of the staffs of all such facilities, of the personal health records of its registrants.

(c) Whenever a registrant with one Health Care Corporation transfers his registration to another such corporation, his personal health record shall be transferred to the latter corporation. To such extent as may be required by regulations of the Secretary, a Health Care Corporation shall make available to other Health Care Corporations, and other providers (not affiliated with it), who furnish emergency or other health services to its registrants, information from the personal health records of the registrants.

(d) Consistent with section 212(b)(6), personal health records, information contained therein, and other information concerning individual registrants or applicants for registration shall be used or disclosed, without the consent of the individual, only (1) in accordance with this section, or (2) for purposes necessary to the administration of the Health Care Corporation, the State plan, or any benefit coverage pursuant to this title. Any person who violates any provision of this subsection shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

PARTICIPATION BY REGISTRANTS; HEALTH EDUCATION

SEC. 248. (a) A Health Care Corporation shall establish methods by which (in addition to their representation on its governing board) registrants may express their views with regard to the policies and operation of the corporation, the health needs of the community, and the need for any modification or expansion of the services furnished by the corporation. The corporation shall take all practicable steps to assure that this opportunity is readily available to all substantia groups (geographic, economic, or other) of registrants, and to the extent practicable, to individual registrants. The corporation shall establish an advisory committee representative of registrants in general, and subcommittees or separate committees representative of any groups whose interests may differ materially from those of other registrants. Through such committee or committees, the corporation shall seek a continuing evaluation by its registrants of its program and performance.

(b) In a manner consistent with the purpose of assuring that individuals are responsible for protecting their own health and for learning to utilize the health services available to them in the most effective manner, the corporation shall undertake a program of continuing health education, with special emphasis directed toward low-income and medically indigent registrants. The program shall be designed and conducted with the advice and participation of representatives of the registrants, for the purpose of overcoming lack of information and correcting misinformation on the part of registrants about personal health matters, encouraging their interest in healthful living, proper nutrition, and the avoidance of illness, and enabling them to make more responsible and effective use of health maintenance services and, when illness occurs, of the diagnostic and therapeutic services available to them. Corporations shall provide, to registrants in need thereof, assistance in overcoming language or educational handicaps in obtaining access to health care. In carrying out this subsection the corporation shall collaborate with governmental and private agencies engaged in community-wide health education.

NONDISCRIMINATION; COMPLAINTS

SEC. 249. (a) In recruitment and registration a Health Care Corporation shall not discriminate on the ground of race, creed, color, national origin, age, sex, occupation, economic status, or condition of health. Subject to such differentiations as are medically necessary or appropriate or are specifically authorized by this title, the corporation and other providers shall not discriminate on any of the foregoing grounds in furnishing services on behalf of the corporation.

(b) The corporation shall establish adequate procedures for the receipt and disposition of complaints by registrants with respect to services furnished them, failure to furnish services or to pay for services furnished by others, or the propriety of charges made by the corporation; and complaints by persons whose applications for registration have been refused. The corporation shall, to such extent and in such form as may be required by the commission, maintain records of such complaints and of their disposition, and shall make such records available for inspection by the commission.

(c) The corporation shall establish adequate procedures for the settlement of disputes with affiliated providers, with other providers having arrangements with the corporation for the furnishing of health care to its registrants, and with nonaffiliated providers.

RESPONSIBILITIES FOR MANPOWER AND FOR RESEARCH

SEC. 250. (a) A Health Care Corporation shall coordinate among its own staff and the staffs of its affiliated providers determination of the needs for the several classes of health personnel, and the recruitment and allocation of such personnel; shall set qualification and performance standards for such personnel, which shall at least equal standards established or recommended by recognized professional organizations; and shall conduct within its own organization and encourage in its affiliated providers such programs of in-service training as it finds necessary or useful in meeting manpower needs, improving the quality of care, and promoting upward mobility within the several health professions and occupations. To the extent permitted by the law of the State in accordance with section 234 (c) (4), and consistent with regulations of the Secretary and good professional practice, the corporation shall encourage the use of physician assistants, allied health professionals, and other supportive technical and nonprofessional personnel, under appropriate professional supervision, to increase the productivity of its medical and dental staff and of affiliated providers and their staffs.

(b) The corporation, in addition to a continuing evaluation of its own performance, shall engage or participate in planning for additional services to respond to identified problem areas and in continuing research concerning the organization and methods of delivery of health services, and concerning their quality, effectiveness, and cost. The results of such research shall be made available to the commission and the Secretary for such dissemination as the commission or Secretary may deem proper.

RECORDS AND REPORTS

SEC. 251. Consistent with section 212(b)(6), a Health Care Corporation shall keep such records, and on behalf of itself and its affiliated providers make such reports to the commission, as the commission, in accordance with regulations of the Secretary, shall require with respect to financial matters, the utilization of services, the results of peer review of quality, and other matters; and shall require that its affiliated providers keep such records and furnish it with such information as may be necessary for this purpose. The corporation and its affiliated providers shall make the records required pursuant to this section available for inspection by representatives of the commission when necessary for the purpose of verification of such reports.

PART E—SPECIAL STUDY OF METHODS FOR MEETING SUPPLEMENTAL CAPITAL NEEDS OF HEALTH CARE CORPORATIONS AND RELATED HEALTH CARE ORGANIZATIONS

FINDINGS AND PURPOSE

SEC. 261. The Congress finds that existing health care institutions in the United States have traditionally obtained their funding for health resource development from a variety of sources, including philanthropy, Federal grants, third-party reimbursement, borrowing, and local bond issues, with the result that the funding of such institutions has been neither adequate, consistent, coordinated, nor equitably distributed. It is the purpose of this part to provide for the development of a more rational approach for supplying the supplemental capital and other funding needed by the health care industry in order to assure a more rational distribution of funds and thereby to meet more effectively the health care needs of the Nation without causing undue cost to individuals in communities which have the greatest health need.

SPECIAL STUDY

SEC. 262. (a) The National Health Services Advisory Council (hereinafter in this section referred to as the "Council"), established by section 213 of this Act, shall conduct a full and complete study and investigation of methods for supplying supplemental capital and other funding for Health

Care Corporations and related health care organizations in the United States, with the objective of developing a national program for supplying such funding, giving special emphasis to areas of high priority health care needs both rural and urban, which will effectively carry out the purpose of this part.

(b) In conducting its study and investigation under subsection (a), the Council shall give particular consideration to the utilization of special taxing mechanisms such as a value-added tax, or tax credits, as means of financing comprehensive benefits for beneficiaries of the national program.

(c) In conducting its study and investigation under subsection (a), the Council shall also give particular consideration to the development of a program which—

(1) establishes and utilizes, as its basic source of funds, a national trust fund consisting of any or all of the following: (A) a designated portion of the premiums collected for comprehensive health care benefits coverage, (B) a tax on such premiums or on such premiums and all other premiums paid for health insurance coverage, (C) appropriated funds, and (D) amounts received from other sources, public or private;

(2) provides for the distribution of amounts in the trust fund to State health commissions in a manner

reflecting population, per capita income, and health care needs, for allocation by such commissions within their respective States to health care corporations and other health care organizations, in the form of grants, loans, or combined grants and loans, on the basis of per capita income, urgency of health care needs in the light of available or potentially available health care resources, and other factors calculated to assure the concentrated expenditure of the available funds in high need areas;

(3) recognizes the need for adequate planning for health care services and facilities, and makes such planning a condition of assistance;

(4) encourages and facilitates the continuing provision of funds for these purposes from sources other than the trust fund, and effectively coordinates the utilization of the amounts provided from such other sources with the amounts distributed from the trust fund;

(5) leaves to each State health commission, under general regulations of the Secretary, the determination of how the funds distributed to such commission are to be allocated and utilized within the State which it represents; and

(6) contains or is subject to such other provisions, conditions, and limitations as may be necessary or ap-

propriate to assure that the purpose of this part will be effectively carried out.

(d) (1) The Council shall submit to the Secretary, for transmission to the Congress no later than one year after the effective date of this Act as specified in section 301 (a), a full and complete report of its study and investigation under this section together with its findings and recommendations and with detailed specifications for any legislation which it finds may be required to carry out such recommendations. The Secretary, in transmitting such report to the Congress, shall include his own comments thereon and his views with respect to the Council's legislative recommendations and specifications.

(2) The special study and investigation conducted by the Council under this section shall be independent of the studies made by the Secretary under section 214; and the report of the Council under this section shall be separate and distinct from its annual report under section 213 (c).

TITLE III—EFFECTIVE DATES

TRANSITIONAL EFFECTIVE DATES

Sec. 301. (a) Except as otherwise provided in this section and sections 210 and 302, this Act (including any amendments made by it to existing law) shall be effective upon the date of its enactment.

(b) Sections 211, 216 (a), 218, 219, 220, and 221, and parts C and D of title II, shall take effect upon the first January 1 or July 1 which occurs six months or more after the date of the enactment of this Act.

(c) Section 216(b), section 238 (with respect to States which have not complied with section 232 and 234), and the amendments made by section 101 shall take effect on the first day of the third fiscal year which begins after the date of the enactment of this Act.

FULL OPERATION OF PROGRAM

SEC. 302. The program under this Act shall be fully in operation, and the benefits under part B of title I shall be fully effective and available (in lieu of any benefits which would otherwise be available under title XVIII of the Social Security Act), in accordance with all of the provisions of this Act, on and after the first day of the fifth fiscal year which begins after the date of the enactment of this Act.

94th CONGRESS
1st Session

H. R. 21

IN THE HOUSE OF REPRESENTATIVES

January 14, 1975

Mr. Corman (for himself, Mr. Green, Mr. Helstoski, Mr. Rangel, Mr. Stark, Mr. Mikva, Mr. Anderson of California, Mr. Bolling, Mr. Brown of California, Mr. Eckhardt, Mr. Edwards of California, Mr. Fraser, Mr. Hawkins, Mr. Hechler of West Virginia, Mr. McFall, Mr. Macdonald of Massachusetts, Mr. Madden, Mr. Meeds, Mr. Moss, Mr. Pepper, Mr. Rodino, Mr. Roybal, Mr. Thompson, Mr. Udall, and Mr. Van Deerlin) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To create a national system of health security.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as "The Health Security Act".

FINDINGS AND DECLARATION OF PURPOSE

Sec. 2. (a) The Congress finds that—

(1) the health of the Nation's people is the foundation of their well-being and of our Nation's strength, productivity, and wealth;

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(2) adequate health care for all of our people must now be recognized as a right; and

(3) a national system of health security is the means to implement that right.

(b) The purpose of this Act is—

(1) to create a national system of health security benefits which, through national health insurance, will make comprehensive health services available to all residents of the United States, will distribute the cost of health care more equitably in relation to income, and will provide major protection against catastrophic costs, and

(2) through the operation of the system, to effect modifications in the organization and methods of delivery of health services which will increase the availability and continuity of care, will enhance its quality, will emphasize the maintenance of health as well as the treatment of illness, and, by improving the efficiency and the utilization of services and by strengthening professional and financial controls, will restrain the mounting costs of care while providing fair and reasonable compensation to those who furnish it.

INITIATION OF HEALTH SECURITY PROGRAM

SEC. 3. Health security taxes will become effective on January 1, and health services will become available on July 1, of the second calendar year after the year in which this Act is enacted. Except for the benefit and related fiscal provisions, title I of this Act is effective upon enactment. Certain federally financed or supported health programs will be terminated or curtailed when health benefits under this Act become available. Effective dates of the several provisions of this Act are set forth in sections 163, 204, 214, 221, 401 to 406 inclusive, and 409.

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TITLE I—HEALTH SECURITY BENEFITS

Part A—Eligibility for Benefits

BASIC ELIGIBILITY

Sec. 11. Every resident of the United States and every nonresident citizen thereof is eligible, while within the United States, to receive health services under this Act; except that an alien employee (as defined in regulations) of a foreign government, of an instrumentality of a foreign government exempt from the taxes imposed by section 3111(b) of the Internal Revenue Code of 1954, or of an international organization (as defined in the International Organizations Immunity Act) is eligible only in accordance with an agreement under section 12. An alien admitted as a permanent resident and living within the United States, an alien admitted for employment and employed within the United States, or a refugee lawfully in the United States is for the purposes of this title a resident of the United States.

AGREEMENTS FOR ELIGIBILITY OF OTHER PERSONS

SEC. 12. The Health Security Board (hereafter referred to as the "Board"), with the approval of the Secretary of Health, Education, and Welfare and the Secretary of State, is authorized to enter into agreements with foreign governments, international organizations, or other entities to extend benefits of this title to persons within the United States not otherwise eligible therefor, in consideration of payment to the United States of the estimated cost of furnishing the benefits to such persons, or of an undertaking to furnish in a foreign country similar benefits to citizens of the United States, or of a combination of payment and such an undertaking.

PART B—NATURE AND SCOPE OF BENEFITS: COVERED SERVICES

ENTITLEMENT TO HAVE PAYMENT MADE FOR SERVICES

SEC. 21. Every eligible person is entitled to have payment made by the Board for any covered service furnished within the United States by a participating provider if the service is necessary or appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following, injury, disability, or disease. Participating providers are providers, described in part C, who meet the conditions stated in section 41. Covered services are services described in sections 22 to 27, inclusive, but are subject to the exclusions stated in section 28 and to limitations prescribed by or pursuant to part H (relating to the quality of care).

PHYSICIAN SERVICES

SEC. 22. (a) Professional services of physicians, furnished in their offices or elsewhere, are covered services. Covered physician services include services and supplies of kinds which are commonly furnished in a physician's office, with or without separate charge, as an incident to his professional services.

(b) Covered physicians' services consist of (1) primary medical services, which are the services (as defined in regulations, but including preventive services) ordinarily furnished by physicians, whether general practitioners or specialists, engaged (as determined in accordance with standards for such practice prescribed in regulations) in general or family practice for adults or for children or for both, and (2) specialized services.

(c) Psychiatric (mental health) service to an outpatient is a covered service (1) only if it constitutes an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders, and (2) only (A) if the service is furnished by a group practice organization, by a hospital, or by a community mental health center or other mental health clinic which furnishes comprehensive mental health services, or (B) if the service is furnished to a patient of a day care service with which the Board has an agreement under section 49 (a) (3), or (C) to the extent of twenty consultations during a benefit period (as defined in regulations), if the service is furnished otherwise than in accordance with clause (A) or (B). In any community in which the available psychiatric services furnished otherwise than in accordance with clause (A) or (B) are found by the Board to be insufficient to meet the needs of the community, the Board may limit the coverage of such services by prescribing referral or other nonfinancial conditions in order to give priority of access to the services to those persons most in need of them.

DENTAL SERVICES

SEC. 23. (a) Professional services (described in subsection (c)) of a dentist, furnished in his office or elsewhere, are covered scervices if they are furnished to a person who, at the time when the services are furnished, is entitled to such services in accordance with subsection (b). Covered services include services, materials, and supplies which are commonly furnished in a dentist's office, without separate charge, as an incident to his professional services.

(b) Persons who, on the effective date of health benefits, are less than fifteen years of age are entitled to covered dental services, and will remain so entitled throughout their lives. On July 1 of each of the five years immediately succeeding the year in which the effective date occurs, the following persons will become (and thereafter remain) entitled to such services: on July 1 of the first succeeding year, persons who are then less than seventeen years of age; on July 1 of the second succeeding year, persons who are then less than nineteen years of age; on July 1 of the third succeeding year, persons who are then less than twenty-one years of age; on July 1 of the fourth succeeding year, persons who are then less than twenty-three years of age; and on July 1 of the fifth succeeding year, persons who are then less than twenty-five years of age.

(c) Covered dental services are preventive services (including personal dental health education), diagnostic services, therapeutic services (exclusive or orthodontic services other than for handicapping malocclusion), and services re-required for rehabilitation following injury, disability, or disease.

(d) The Board is authorized, if it finds that the availability of funds and of facilities and personnel makes it possible, to provide by regulation for acceleration of the entitlement (by age groups) to covered dental services as set forth in subsection (b). Not later than seven years after the effective date of health benefits, the Board shall by regulation provide that entitlement to dental services shall be extended, over such period of time and by such age or other groupings as it finds calculated to make the best use of available resources and personnel, to all persons not otherwise entitled to such services; and it may thereafter, from time to time, amend such regulations on the basis of further experience in the furnishing of dental services as covered services. In exercising its authority under this subsection the Board shall seek to encourage the furnishing of dental services as a part of comprehensive health services, or the furnishing of them by organizations furnishing comprehensive dental services (which meet requirements set forth in regulations under section 104 (a)) ; and to that end, the Board may limit additional entitlement to dental services, in whole or in part and temporarily or permanently, to services so furnished.

INSTITUTIONAL SERVICES

SEC. 24. (a) Inpatient and outpatient services of a psychiatric or other hospital, the services of a skilled nursing home, and the services of a home health service agency, which are ordinarily furnished by the institution to patients for the purposes stated in section 21, are covered services, subject to the limitations stated in this section. Covered services include services furnished generally to the patients served by an institution, including pathology and radiology services and all other necessary services, whether they are furnished by the institution or by others under arrangement with the institution. To the extent provided in regulations, inpatient services of a Christian Science sanatorium are covered services.

(b) Covered services do not include personal comfort items or, unless required for medical reasons, the additional cost of accommodations more expensive than semiprivate accommodations; and do not include domiciliary or custodial care, or institutional care of a person while he is not receiving active medical treatment.

(c) Covered services do not include care in a skilled nursing home for more than one hundred and twenty days during a benefit period (as defined in regulations); except that the Board may, on such conditions as it finds appropriate to assure effective control of utilization, extend the duration of covered services, either for a stated number of days in a benefit period or indefinitely—

(1) in all skilled nursing homes for which consolidated budgets with hospitals have been approved under section 83 (f), or

(2) in all participating skilled nursing homes having in effect affiliation agreements under section 52 (b), if the Board finds that adequate funds and resources are available therefor and that such action will not lead to excessive utilization of nursing home services.

(d) Covered services do not include institutional care of a person as a psychiatric patient while the patient is not receiving active treatment for an emotional or mental disorder; and do not include care of a person as a psychiatric patient for more than forty-five inpatient days in either a psychiatric or another hospital during a benefit period (as defined in regulations).

(e) Covered services do not include institutional care of an inpatient unless a physician has certified to the medical necessity of the patient's admission to the institution, and do not include such care (during a continuous stay in the institution) after such period (if any) as may be specified in regulations unless a physician has certified to the continued medical necessity of such care. Regulations may specify the classes of cases in which certification of continued necessity is required, may specify different periods for different classes of cases, and may permit retroactive certification under such circumstances and to such extent as the Board deems appropriate.

(f) Covered services do not include the services of a psychiatric or other hospital or skilled nursing home, during a benefit period (as defined in regulations), after the third day following receipt by the institution and the patient of notice of a finding by a utilization review committee pursuant to section 51(e) that further stay in the hospital or further stay in the nursing home, as the case may be, is not medically necessary.

PHARMACEUTICAL BENEFITS

SEC. 25. (a) The Board shall establish and disseminate (and review at least annually) (1) a list of drugs for use in participating institutions, group practice organizations, and individual practice associations, and (2) a list (for use outside such institutions, organizations, and associations) of diseases and conditions for the treatment of which drugs may be furnished as a covered service, and a specification of the drugs that may be so furnished for each disease or condition listed. Subject to the provisions of subsections (b) and (c), the furnishing of a drug to an eligible person is a covered service if it is furnished by or on prescription of a participating physician or dentist, or by or on prescription of a physician or dentist acting on behalf of a participating institutional or other provider.

(b) The list of drugs referred to in subsection (a)(1) shall be designed to provide physicians and dentists with an armamentarium necessary and sufficient for rational drug therapy incident to comprehensive medical services or incident to covered dental services. The furnishing of a drug on this list is a covered service if it is furnished to a person who is enrolled in a participating group practice organization or individual practice association, or is administered within a participating hospital to an inpatient or an outpatient or is administered to an inpatient of a participating skilled nursing home operated by a participating hospital or having in effect an affiliation agreement in accordance with section 52(b).

(c) The list of diseases and conditions referred to in subsection (a)(2) shall include those chronic diseases and conditions for which drug therapy, because of its duration and cost, commonly imposes substantial financial hardship; and may include other diseases and conditions for which the Board finds costly drug therapy to be commonly required and effective. To assure proper utilization of drugs for specific diseases or conditions, the Board may require that the physician or dentist furnishing or prescribing a listed drug be a specialist qualified to diagnose and treat that disease or condition. The furnishing of a drug (although not to a person or under circumstances described in subsection (b)) is a covered service if (1) the physician or dentist furnishing or prescribing it identifies the disease or condition for which it is furnished or prescribed, and the disease or condition is one appearing on the Board's list, (2) the physician or dentist meets specialist qualifications, if any, required by the Board, and (3) the drug is specified on the Board's list as one available for treatment of the disease or condition identified by the physician or dentist.

(d) The Board shall not list a drug under this section unless (1) the Secretary has found that it is safe and efficacious for the purposes for which it is recommended and (on the list established under subsection (c)) for the treatment of each disease or condition for which it is specified on the list, and (2) the Board finds that it is available at a reasonable cost (considering, among other factors, the existence or absence of competition in the production, distribution, and sale of the drug). Drugs shall be listed by their established names (as defined in section 502(e) of the Federal Food, Drug, and Cosmetic Act) and also, to the extent the Board deems appropriate, by trade names.

(e) In reviewing and revising lists established under this section the Board shall take into consideration (1) current information about the safety and efficacy of listed drugs, and about their cost, (2) the results of review of drug utilization under this title, (3) experience bearing on the determination of what diseases and conditions meet the criteria stated in subsection (c), and (4) such other factors as the Board deems pertinent. Drugs shall be added to or eliminated from the lists as the Board finds best calculated to effectuate the purposes of this section.

DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 26. (a) The Board shall establish and disseminate (and review at least annually) lists of the therapeutic devices, appliances, and equipment (including eyeglasses, hearing aids, and prosthetic appliances), or classes thereof, which it finds are important for the maintenance or restoration of health or of employability or self-management. The Board shall take into consideration the efficacy, reliability, and cost of each item listed, and shall attach to any item such conditions as it deems appropriate with respect to the circumstances under which or the frequency with which the item may be prescribed. In establishing and revising lists under this section the Board shall seek to avoid a rate of expenditure for the furnishing of devices, appliances, and equipment in excess of 2 per centum of the rate of expenditure for all covered services.

(b) The furnishing of a device, appliance, or equipment prescribed by a participating physician or dentist, or by a physician or dentist acting on behalf of a participating institutional or other provider, is a covered service if the item appears on a current list established under subsection (a) and the prescription falls within any conditions attached, on the list, to the prescribing of that item. The furnishing of any other device, appliance, or equipment so prescribed is also a covered service if, in accordance with regulations, the furnishing of it has been approved in advance by the Board. Regulations under this section may list items or classes of items which, because of lack of efficacy or reliability or because of cost, the Board has determined may not be furnished as covered services.

OTHER PROFESSIONAL AND SUPPORTING SERVICES

SEC. 27. (a) To the extent provided in regulations, the following are covered services:

(1) the professional services of optometrists in the examination, diagnosis, and treatment of conditions of the vision system;

(2) the professional services of podiatrists;

(3) the diagnostic services of independent pathology laboratories, and diagnostic and therapeutic radiology furnished by independent radiology services;

(4) the care of a patient in a mental health day care service (A) for not more than sixty full days (or its equivalent) during or following a benefit period (as defined in regulations), when furnished by a hospital or a service affiliated with a hospital, or (B) if furnished by a group practice organization or by a community mental health center or other mental health center

which furnishes comprehensive mental health services, or (C) if furnished by a mental health day care service with which the Board has an agreement under section 49 (a) (3);

(5) in addition to the services available from hospitals, mental health centers, or other providers, the active treatment of a person with an established diagnosis of alcoholism or drug abuse, as an outpatient, in a freestanding ambulatory center (that is, a center the services of which are not furnished on behalf of another provider) with which the Board has an agreement under section 49 (a) (5) for the treatment of persons with such diagnosis;

(6) in addition to the services available from other providers, family planning services furnished by a freestanding family planning center with which the Board has an agreement under section 49 (a) (6);

(7) in addition to the services available from other providers, rehabilitation services furnished by a freestanding rehabilitation center with which the Board has an agreement under section 49 (a) (7); and

(8) ambulance and other emergency transportation services, and such nonemergency transportation services as the Board finds essential to overcome special difficulty of access to covered services.

(b) Supporting services (such as psychological, physiotherapy, nutrition, social work, or health education services) are covered services when they are furnished on behalf of an institutional provider or when, with the approval of the Board, they are furnished on behalf of a group practice organization or individual practice association, or of an organization, agency, or center with which the Board has an agreement under section 49 (a) ; but only if the persons furnishing the supporting services are compensated on a salary, stipend, or capitation basis by the provider on whose behalf they are furnished.

EXCLUSIONS FROM COVERED SERVICES

SEC. 28. (a) Health services furnished or paid for under a workmen's compensation law of the United States or a State, or legally required to be so furnished or paid for, are not covered services. Such services, if furnished by a participating provider to an eligible person, shall nevertheless be treated as covered services in accordance with this part unless and until a determination has been made pursuant to the workmen's compensation law that the services are covered by that law, and any resulting overpayment under this title shall, when payment is made under the workmen's compensation law, be recouped in the same manner as other overpayments.

(b) Health services furnished in a primary or secondary school are covered services only to such extent and on such conditions as may be specified in regulations.

(c) Surgery performed solely for cosmetic purposes (as defined in regulations), and hospital or other services incident thereto, are not covered services.

(d) The furnishing of a drug otherwise than in accordance with section 25 is not a covered service. The furnishing of a device, appliance, or equipment otherwise than in accordance with section 26 is not a covered service unless it is furnished, in accordance with section 22(a) or section 23(a), as an incident to professional services.

(e) The Board may by regulation exclude from covered services medical or surgical procedures (and services incident thereto) which it finds both (1) are essentially experimental in character, and (2) because of cost or because of shortage of qualified personnel or facilities cannot practicably be furnished on a nationwide basis.

(f) Except as provided in regulations, services are not covered services if (1) they are furnished by another provider to a person who has enrolled in a participating group practice organization or in a participating individual practice association, and are within the range of services which the organization or association has undertaken to furnish, or (2) they are primary physicians' services or covered dental services and are furnished by another provider to a person who has chosen to be on the list of a physician or a dentist electing to be paid by the capitation method. Regulations under this subsection shall permit termination of the enrollment referred to in clause (1), or of the choice referred to in clause (2), after the enrollment or choice has been in effect for twelve months, or at an earlier time for such reasons as may be specified in the regulations.

(g) The services of a professional practitioner are not covered services if they are furnished in a hospital which is not a participating provider, or are furnished to a psychiatric inpatient of an institution at a time when the institutional services to the patient are, by reason of section 24 (d), not covered services.

PART C—PARTICIPATING PROVIDERS OF SERVICES

IN GENERAL: AGREEMENTS WITH THE BOARD

SEC. 41. (a) A person, corporation, or other entity furnishing any covered service is a participating provider if he or it (1) is a qualified provided of that service, as determined in accordance with this part, and meets such requirements as are prescribed by or pursuant to part H (relating to the quality of care), (2) furnishes the service as an independent provider and not (as employee or otherwise) on behalf of another provider entitled under part E to payment for the service, and (3) has filed with the Board an agreement (A) that services to eligible persons will be furnished without discrimination on the ground of race, color, or national origin, (B) that no charge will be made for any covered service other than for payment authorized by this title, (C) that the provider will furnish such information and reports as may be required under this title for the making of payments, or as the Board may reasonably require for utilization review by professional peers or for statistical or other studies of the operation of the title (including information and reports required for the purposes of the Commission on the Quality of Health Care), and will permit such examinations of records as may be necessary for verification of information on which payments are based, and (D) in the case of an institutional provider, a group practice organization, an individual practice association, or other provider specified in regulations of the Board, that it will comply with such requirements as the Board finds necessary to assure to the employees of the provider protection of employment rights and working conditions, including the right to collective bargaining, equal, as nearly as may be, to the protection generally available to industrial employees under Federal law or under the law of the State in which the provider is situated.

(b) Participation of a provider may be suspended or terminated pursuant to section 132 or section 134.

(c) If a provider subject to clause (D) of subsection

(a) (3) is merged, consolidated, or otherwise reorganized in a manner affecting the employment or rights of its employees, the Board shall require, as a condition of participation by the merged, consolidated, or reorganized provider, that it undertake to comply with reasonable requirements of the Board for the protection of the preexisting rights, benefits, and privileges of the employees of the provider or providers involved in the merger, consolidation, or reorganization. If a provider subject to clause (d) which is an agency of a State or local government, is closed, the Board is authorized, for the purpose of this subsection, to treat the closure as a consolidation with such other agency or agencies of the same unit of government as it finds will perform the principal functions of the provider which has been closed.

PROFESSIONAL PRACTITIONERS

SEC. 42. (a) A physician, dentist, optometrist, or podiatrist, legally authorized on the effective date of health security benefits to practice his profession in a State, is a qualified provider of covered services within the State. A practitioner first so authorized by a State after the effective date is a qualified provider in that State if, in addition, he meets national standards established by the Board (taking into consideration the criteria applied by any recognized national testing organization) for the practitioner's profession. A practitioner who is a qualified provider in one State, if he meets the national standards, is also in any other State (in accordance with the provisions of section 56(a)(1) a qualified provider of services which (1) are covered services to persons entitled thereto under this title, and (2) are of a kind which such other State authorizes to be furnished by practitioners of his profession.

(b) For the purposes of this title—

(1) a doctor of osteopathy legally authorized to practice medicine and surgery in a State is a physician;

(2) a dentist qualified in accordance with subsection (a) is a physician when performing oral surgery or other procedures which, in accordance with generally accepted professional standards, may be performed by either a physician or dentist; and

(3) a doctor of optometry or podiatry qualified in accordance with subsection (a) is a physician when furnishing services which are covered services in accordance with regulations issued under section 27(a) and which he is legally authorized to furnish in the State in which he furnishes them.

GENERAL HOSPITALS

SEC. 43. Subject to the provisions of section 53, a hospital (other than a psychiatric hospital) is a qualified provider if it is an institution which—

(a) is primarily engaged in providing to inpatients (other than mentally ill persons) diagnostic, therapeutic, and rehabilitation services, furnished by or under the supervision of physicians, for medical diagnosis, treatment, care, and rehabilitation of injured, disabled, or sick persons;

(b) maintains adequate clinical records on all patients;

(c) has bylaws in effect with respect to its staff of physicians, and has filed with the Board an agreement that in granting or maintaining medical staff privileges it will not discriminate on any ground unrelated to professional qualifications;

(d) has a requirement that every patient must be under the care of a physician;

(e) provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(f) has a pharmacy and drug therapeutics committee which establishes policies for the selection, acquisition, and utilization of drugs;

(g) has in effect a hospital utilization review plan which meets the requirements of section 51; and

(h) meets all applicable requirements of the law of the State in which it is situated.

PSYCHIATRIC HOSPITALS

SEC. 44. Subject to the provisions of section 53, a hospital which is primarily engaged in furnishing psychiatric services to inpatients who are mentally ill is a qualified provider if it (or a distinct part of it) is an institution—

(a) in which diagnostic, therapeutic, and rehabilitative services with respect to mental illness are furnished by or under the supervision of physicians;

(b) which satisfies the requirements of subsections (b) through (h) of section 43;

(c) which, on the basis of staffing and other factors it deems pertinent, the Board finds is qualified to furnish active treatment; and

(d) which maintains such records as the Board finds necessary to determine the degree and intensity of the treatment furnished.

SKILLED NURSING HOMES

SEC. 45. Subject to the provisions of sections 52 and 53, a skilled nursing home is a qualified provider if it (or a distinct part of it) is an institution which—

(a) is primarily engaged in providing to inpatients (other than mentally ill persons) skilled nursing care and related services for patients who require medical and nursing services;

(b) has written policies, which are developed (and reviewed from time to time) with the advice of a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the services it provides;

(c) has a medical staff, a physician, or a registered professional nurse responsible for the execution of such policies;

(d) unless it is operated by a participating hospital, operates under the supervision of an administrator licensed by the State in which the institution is situated;

(e) has a requirement that the health care of every patient be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;

(f) maintains adequate clinical records on all patients;

(g) provides twenty-four-hour nursing service sufficient to meet nursing needs in accordance with the policies developed as provided in subsection (b), and has at least one registered professional nurse employed full time;

(h) provides appropriate methods and procedures for the dispensing and administering of drugs;

(i) has in effect a utilization review plan which meets the requirements of section 51; and

(j) meets all applicable requirements of the law of the State in which it is situated and, unless the Board finds that such law provides equivalent protection, meets the provisions of the Life Safety Code of the National Fire Protection Association (other than any provision of the code authorizing waiver of its requirements) applicable to nursing homes.

HOME HEALTH SERVICE AGENCIES

SEC. 46. Subject to the provisions of section 52, a home health service agency is a qualified provider if it is a public agency or a nonprofit private organization, or a subdivision of such an agency or organization, which—

(a) is primarily engaged in furnishing, on an intermittent and visiting basis in patients' homes, skilled nursing and other therapeutic services to patients (other than mentally ill persons) who are under the care of physicians;

(b) has written policies developed (and reviewed from time to time) by a group of professional personnel associated with the agency or organization, including one or more physicians and one or more registered professional nurses, to govern the services which it furnishes, and provides for supervision of such services by a physician or registered professional nurse;

(c) maintains adequate clinical records on all patients;

(d) meets all applicable requirements of the law of the State in which it furnishes services; and

(e) has written policies and procedures which provide for a systematic evaluation of its total program at appropriate intervals in order to assure the appropriate utilization of services.

GROUP PRACTICE ORGANIZATIONS

SEC. 47. (a) A group practice organization (a type of health maintenance organization) is a qualified provider if—

(1) it is a public or other nonprofit organization which furnishes health services to persons enrolled in the organization;

(2) it provides at least annually an open enrollment period of not less than thirty days, during which all eligible persons living within a defined service area (or living near enough thereto to have reasonably ready access to the services of the organization), up to the capacity of the organization to furnish services, are accepted for enrollment in the order in which they apply, except that priority may by given to persons living within the service area; and it does not terminate any enrollment because of the enrollee's health status or his need

or demand for health services, or for any other reason except repeated and serious violation of reasonable rules of the organization;

(3) it undertakes to provide to its enrollees, at its expense and in accordance with paragraphs (4) and (5), all of the covered services described in part B, including such supporting services as the Board may have approved under section 27 (b) ; except that it may exclude some or all mental health services or dental services if it assures referral of its enrollees to providers of such excluded services when medically appropriate and maintains arrangements with such providers for the availability of the services to its enrollees;

(4) all physician services, and dental services if the organization undertakes to provide them, are (except for infrequently used services) furnished by a medical group which meets the following conditions, or by two or more groups each of which meets such conditions—

(A) the group consists of physicians, or of physicians and dentists, with or without other professional health personnel, sufficient in number and possessing among them the necessary qualifications to furnish all covered physician services and the dental service (if any) which the group practice organization undertakes to provide (except infrequently used services) ; and

(B) the members of the group (i) as their principal professional activity practice their profession as a group responsibility in furnishing services to enrollees of the group practice organization, (ii) pool their income from practice as such members (unless they are compensated by salary or stipend by the group practice organization) and distribute it among themselves in accordance with a prearranged salary, percentage, or similar plan, and (iii) jointly use medical and other records, a substantial part of their major equipment, and the services of professional, technical, and administrative staff (including personnel furnishing supporting services approved under section 27 (b)) ;

(5) all services, other than physician services and dental services, which the organization undertakes to provide (except infrequently used services) are furnished through its own staff and facilities (or are furnished by others under contract, if the organization retains control of, and full responsibility for, the availability and quality of the services) ; except that institutional services may be provided through arrangements

with other participating providers (either nonprofit or for profit) for the availability of services;

(6) the organization encourages health education of its enrollees (including education in the appropriate use of health services) and the development and use of preventive health services, and furnishes and arranges services and (to the extent practicable) arranges its system of medical records in such a manner as to facilitate continuity of care, and to the maximum extent feasible makes all services (including emergency services at all times) readily accessible to enrollees who live in its service area;

(7) it makes available to its enrollees and to the public full information about the services it provides and their availability, and such other information about its operations and the utilization of services as the Board may by regulation require;

(8) it provides an opportunity for representatives of its enrollees to participate effectively in the formulation of policies of the organization and in the evaluation of its operation, and provides fair and effective procedures for resolving disputes between enrollees and the organization or providers with whom it has contracted or has arrangements for the furnishing of service;

(9) it provides that a committee or committees of physicians (with other health professionals where appropriate) associated with the organization promulgate professional standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the utilization and quality of all health services (including drugs);

(10) to the extent practicable and consistent with good medical practice, it employs allied health personnel and subprofessional and lay personnel in the furnishing of services;

(11) it assumes the financial responsibility, without benefit of insurance except in accordance with section 87(e), for assuring to its enrollees the services which it has undertaken to provide;

(12) its premiums or other charges for any services not paid for under this title are reasonable; and

(13) it undertakes, to the extent required by regulations with respect to services of the kinds it has undertaken to provide, to arrange for reciprocal out-of-area services by other group practice organizations, or to pay for health services furnished to its enrollees by other participating providers, in emergencies, within or outside the service area of the organization.

(b) A group practice organization, or with its approval a professional practitioner who furnishes services on its behalf, may furnish services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made by one of the methods provided in part E for payment to independent practitioners, and shall be made to the organization unless the organization requests that it be made to the practitioner who furnishes the services and he is a participating provider.

INDIVIDUAL PRACTICE ASSOCIATIONS

Sec. 48. (a) An individual practice association (a type of health maintenance organization) is a qualified provider if—

(1) it is an organization sponsored by a county or other local medical society, with a service area coextensive with the area of its sponsoring society, which meets the conditions set forth in section 47 (a) (relating to group practice organizations) other than paragraph (4) thereof;

(2) all physician services, and dental services if the association undertakes to furnish them, are (except for infrequently used services) furnished by professional members of the association, who are compensated by whatever method or methods (including fee-for-service)

may be agreed upon by the association and its professional members; and

(3) the association permits any physician (or dentist, if the association undertakes to furnish dental services) practicing in its service area, whether or not a member of the sponsoring society, subject only to criteria (approved by the Board) of professional qualifications, to become a professional member of the association to furnish services on its behalf.

(b) A professional member of an association, unless he has agreed otherwise with the association, may furnish services to persons who are not enrolled in the association, and payment for the services, if they are covered services to an eligible person, shall be made by one of the methods provided in part E for payment to independent practitioners. The payment shall be made to the professional member, except that if he is compensated by the association for services to enrollees on a salary, stipend, or capitation basis (or if he is not a participating provider) the payment shall be made to the association.

OTHER HEALTH SERVICE ORGANIZATIONS

SEC. 49. (a) Pursuant to an agreement with the Board containing such terms and conditions, and prescribing such standards, as the Board deems proper, any of the following is a qualified provider of such services as are specified in the agreement—

(1) a public or other nonprofit agency or organization (including a hospital) which furnishes all of the covered services described in part B, including such supporting services as the Board may have approved under section 27 (b), except that it may exclude some or all institutional services, mental health services, or dental services if it assures referral of its patients to providers of such services when medically appropriate and maintains arrangements with such providers for the availability of the services to its patients;

(2) a public or other nonprofit center (including a satellite center established by a hospital) which (A) furnishes, as a minimum, the services of two or more physicians engaged in general or family practice, the services of nurses and supporting personnel, and basic laboratory services, which the Board finds sufficient for the primary medical care of a substantial population living in the vicinity of the center, and (B) has arrangements with other providers of services which the Board finds assure to the population served by the center, on a coordinated basis, all components of the covered health services described in part B;

(3) a public or other nonprofit mental center or mental health day care service;

(4) a State or local public health agency furnishing preventive or diagnostic services, or a public agency furnishing covered health services in a primary or secondary school in accordance with regulations issued under section 28 (b) ;

(5) a freestanding ambulatory treatment center for the treatment of alcoholism or drug abuse, or both;

(6) a freestanding center for the furnishing of family planning services;

(7) a freestanding center for the furnishing of rehabilitation services; or

(8) a medical or dental group practice or clinic, a dental foundation, or another organization or agency furnishing health services to ambulatory patients.

(b) An agreement under this section shall not, except to the extent that it specifically so provides, preclude a professional practitioner who furnishes services on behalf of the provider from furnishing also, either on behalf of the provider or as a participating independent practitioner, services which are of a kind not within the scope of the agreement or are furnished to persons not within its scope. Unless the agreement provides that payment for covered services furnished to eligible persons shall be made to the provider who has entered into the agreement, payment shall be made to the practitioner by one of the methods provided in part E for payment to independent practitioners.

OTHER PROVIDERS

SEC. 50. (a) An independent pathology laboratory (as defined in regulations) is a qualified provider of diagnostic pathology services if (whether or not it is engaged in transactions in interstate commerce) it meets the requirements established by or pursuant to section 353 of the Public Health Service Act. An independent radiology service (as defined in regulations) is a qualified provider of diagnostic and therapeutic radiology if it meets all applicable requirements of the law of the State in which the services are furnished.

(b) A provider of drugs, devices, appliances, or equipment is a qualified provider if he meets all applicable requirements established by or pursuant to the Federal Food, Drug, and Cosmetic Act and all requirements of the law of the State in which the provider is situated.

(c) A provider of ambulance or other covered transportation services is a qualified provider if he meets all applicable requirements of the law of the State in which the services are furnished.

(d) A Christian Science sanatorium is a qualified provider of services specified in regulations prescribed under section 24 (a) if it is operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

UTILIZATION REVIEW

SEC. 51. A utilization review plan of a psychiatric or other hospital or a skilled nursing home shall be considered sufficient if it provides—

(a) for the periodic review on a sample or other basis (and the maintenance of adequate records of such review) of admissions to the institution, the duration of stays, and the professional services (including drugs) furnished, (1) with respect to the medical necessity of the services, and (2) for the purpose of promoting the most efficient use of available health facilities and services; and provides for periodic reports, to the institution and the medical staff (and, when requested, to the Board), of statistical summaries of the review;

(b) in the case of a psychiatric or other hospital, for such review to be made either (1) by a staff committee of the hospital composed of two or more physicians (consulting, with respect to drug utilization, with the pharmacy and drug therapeutics committee), with or without participation of other professional personnel, or (2) by a group outside the hospital which is similarly composed and which, if practicable, is established by the local medical society and hospitals in the locality, or is established in such other manner as may be approved by the Board; but clause (1) of this subsection shall be inapplicable to any hospital where, because of its small size or for such other reason as may be specified in regulations, it is impracticable for the hospital to have a properly functioning staff committee for the purposes of this section;

(c) in the case of a skilled nursing home, for such review to be made by a committee, composed and established as provided in subsection (b), or by a committee so composed which is established by the State or local public health agency pursuant to a contract with the Board, or by the Board; except that if a consolidated budget has been approved for the nursing home and a hospital, under section 83 (f), the review shall be made by the utilization review committee of the hospital;

(d) for such review, in each case of inpatient hospital services or skilled nursing home services furnished to a patient during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible after each day so specified, and in no event later than one week following such day; and

(e) for prompt notification to the institution, the patient, and his attending physician of any finding (made after opportunity for consultation afforded to such attending physician) by the physician members of such committee or group that any admission, further stay, or furnishing of particular services in the institution is not medically necessary.

TRANSFER AND AFFILIATION AGREEMENTS

SEC. 52. (a) A skilled nursing home is a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensed with) a transfer agreement with at least one participating hospital, providing for the transfer of patients and of medical and other information between the institutions as medically appropriate.

(b) After two years following the effective date of health benefits, a skilled nursing home or a home health service agency will be a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensing with) an affiliation agreement with a participating hospital or a participating group practice organization, under which the medical staff of the hospital or organization (or a committee thereof) will furnish, or will assume responsibility for, the professional services in the skilled nursing home, or the professional services furnished by the home health agency, as the case may be.

(c) The requirement of a transfer agreement under subsection (a), or of an affiliation agreement under subsection (b), shall not be applicable in any case if there is in effect a finding by the Board that the lack of a suitable hospital or organization within a reasonable distance makes such an agreement impracticable, and that the services of the skilled nursing home or the home health agency are essential to avoid a critical shortage of services to eligible persons. Such a finding shall be reviewed periodically, and shall be revoked whenever the Board finds it practicable to do so.

NEWLY CONSTRUCTED FACILITIES

SEC. 53. A psychiatric or other hospital or a skilled nursing home, or a provider operating a facility for ambulatory care, is not a participating provider if construction or substantial enlargement of the facility (whether or not in replacement of another facility) was undertaken (as defined in regulations) after December 31 of the year in which this title is enacted unless (a) the construction or enlargement is in accord with a State certificate of need, or has been found by a State agency designated by the Governor of the State for this purpose, or has been found by the Board, to be needed for the furnishing of adequate services to persons residing in the area to be served by the institution, or (b) in the case of enlargement of an existing facility, the Board has found (regardless of the need for the enlargement) that the facility is needed for that purpose. (For provision relating to reduction in payments in certain cases referred to in clause (b), see section 89.)

LIMITATIONS ON MALPRACTICE JUDGMENTS

SEC. 54. In any litigation in any court of the United States or any State seeking damages for injury caused by negligence or other fault in the furnishing of any service covered by this Act, no damages shall be awarded for the cost of remedial services for which the injured party was or is entitled to have payment made under this Act (or for which he would have been, or would be, entitled to have payment made upon obtaining the services from a participating provider).

EXCLUSION: FEDERAL PROVIDERS OF SERVICES

SEC. 55. No institution of the Department of Defense, no institution of the Veterans' Administration, no institution of the Department of Health, Education, and Welfare engaged in the provision of services to merchant seamen or to Indians or Alaskan Natives, and no employee of any of the foregoing acting as employee, is a participating provider. The Board shall, however, reimburse the proper appropriation for any covered services furnished by any such institution or employee to an eligible person who is not, under any Act other than this Act, eligible to receive the service from the institution or employee. The Board shall also reimburse the proper appropriation for any covered services furnished to eligible persons pursuant to section 329 of the Public Health Service Act, such reimbursement to be in lieu of payments required by section 329 (b) of that Act.

RESTRICTIVE STATE LAW INOPERATIVE

SEC. 56. (a) In the furnishing of covered services to eligible persons (any law of a State or political subdivision to the contrary notwithstanding)—

(1) A physician, dentist, optometrist, or podiatrist who is legally authorized by a State to practice his profession and who meets national standards established by the Board pursuant to section 42 (a) is hereby authorized to furnish in any other State, either as an independent participating provider or on behalf of an institutional or other participating provider, the services which such other State authorizes to be furnished by practitioners of his profession.

(2) A professional nurse, or a practitioner of another health profession or occupation designated in regulations, who meets national standards established by the Board for his profession or occupation is hereby authorized to furnish in any State, on behalf of participating providers of services, the services which that State authorizes or permits to be furnished by practitioners of his profession or occupation. National standards applica-

ble to professional nursing, or to any other profession or occupation the practice of which is subject in all States to licensure or similar authorization, shall contain a requirement of licensure or authorization by at least one State.

(3) In a participating public or other nonprofit hospital or a participating group practice organization, a practitioner of any health profession other than medicine or dentistry or of any nonprofessional health occupation who meets national standards established by the Board for his profession or occupation, and meets any additional qualifications established by the Board for the performance of particular acts or procedures, is hereby authorized to perform, under the supervision and responsibility of a physician or dentist, such of the acts which might lawfully be performed by the physician or dentist as are specified in regulations.

(4) A participating public or other nonprofit hospital or a participating group practice organization is hereby authorized (whether or not the arrangement may be deemed to constitute corporate practice of a profession) to employ physicians, dentists, or other professional practitioners, or to obtain and compensate their services in any other manner, and the practitioners

are authorized to serve such a hospital or organization as employees or in any other manner; but only if the employment or other arrangement is not of a kind which the Board finds is likely to cause lay interference with professional acts or professional judgments.

(b) If the Board finds that a proposed corporation will meet the requirements of section 47 (a) for participation as a group practice organization, but that it cannot be incorporated in the State in which it proposes to furnish services because the State law requires that a medical society approve the incorporation of such an organization, or requires that physicians constitute all or a majority of its governing board, or requires that all physicians in the locality be permitted to participate in the services of the organization, or makes any other requirements which the Board finds incompatible with the purposes of this title, the Board may issue a certificate of incorporation to the organization, and it shall thereupon become a body corporate. The powers of the corporation shall be limited to the furnishing of services under this title, and the doing of things reasonably necessary or incident thereto. So far as the Board finds to be compatible with the purposes of this title, the certificate of incorporation shall accord with, and the corporation shall be subject to, provisions of the State law which are applicable to nonprofit corporations generally.

The corporation shall not be deemed to be an instrumentality of the United States for purposes of exemption from any Federal or State law.

PART D—TRUST FUND; ALLOCATION OF FUNDS FOR SERVICES

HEALTH SECURITY TRUST FUND

SEC. 61. (For the text of section 61, see section 406, transferring section 1817 of the Social Security Act to this Act, redesignating it as section 61, and amending it.)

ANNUAL DETERMINATION OF FUND AVAILABILITY

SEC. 62. (a) For each fiscal year the Board shall, not later than June 1, next preceding the beginning of the fiscal year, fix the maximum amount which may (except as provided in subsection (c)) be obligated during the fiscal year for expenditure from the trust fund. The amount so fixed—

(1) shall not exceed 200 per centum of the expected net receipts during the fiscal year (as estimated by the Secretary of the Treasury) from the taxes imposed by sections 1401(b), 1403, 3101(b), and 3111 (b) of the Internal Revenue Code of 1954, and

(2) for any fiscal year (except for the period between the effective date of health benefits and the end of the first fiscal year beginning thereafter), shall not exceed the aggregate obligations, as estimated by the Board, incurred and to be incurred by the trust fund

during the fiscal year current at the time when the determination is made, adjusted to reflect (A) any estimated change expected in the prices of goods and services which enter into the cost of living, (B) the expected change in the number of eligible persons, (C) any expected change (to the extent that the Board finds it not otherwise adequately reflected) in the number of participating professional providers, or in the number or capacity for the provision of services of institutional or other participating providers, and (D) any change in the cost of administration of this Act indicated in the President's budget estimates pursuant to section 201 (g) of the Social Security Act.

(b) In fixing the amount to be available for obligation during a fiscal year, pursuant to subsection (a)—

(1) if and to the extent that (A) the Board estimates that the amount in the trust fund at the beginning of the fiscal year will be less than one-quarter of the obligations incurred and to be incurred during the fiscal year current at the time when the determination is made, and (B) the Board finds that restriction of the amount to be available for obligation will not materially impair the adequacy or quality of services to eligible persons, the amount fixed under subsection (a) shall be

less than the maximum stated in paragraph (1) of that subsection; and

(2) if and to the extent that the Board finds that improvement in the organization and delivery of services or in the control of their utilization has lessened their aggregate cost (or has lessened an increase in their aggregate cost), the amount fixed under subsection (a) shall be less than the maximum stated in paragraph (2) of that subsection.

(c) The amount to be available for obligation during a fiscal year, fixed pursuant to subsection (a), may be modified before or during the fiscal year if the Secretary of the Treasury finds that the tax receipts referred to in subsection (a) (1) will differ from the estimate by 1 per centum or more, of if the Board finds that any of the factors of expected change referred to in subsection (a) (2), or action on the budget estimate for the cost of administration, will differ from the estimate by 5 per centum or more; or if an epidemic, disaster, or other occurrence increases the need for health services to an extent which the Board finds requires the expenditure of additional funds. If the amount fixed pursuant to subsection (a) is increased, the Board shall promptly report its action to the Congress with a statement of the reasons therefor.

HEALTH SERVICES ACCOUNT, HEALTH RESOURCES DEVELOPMENT ACCOUNT, ADMINISTRATION ACCOUNT, AND GENERAL ACCOUNT

SEC. 63. (a) There shall be established in the Trust Fund a health services account, a health resources development account, an administration account, and a general account (consisting of all moneys in the Trust Fund which have not been transferred to another account).

(b) For each fiscal year there shall from time to time be transferred from the general account to the health resources development account the following percentage of the amount to be available for obligation during that year (as determined pursuant to section 62 (a) and (b)): for the fiscal year beginning on the effective date of health benefits, and for the next succeeding fiscal year, 2 per centum; for each of the next two succeeding fiscal years, 3 per centum; for each of the next two succeeding fiscal years, 4 per centum; and for each fiscal year thereafter, 5 per centum. Funds in the health resources development account shall be used exclusively for the purposes of part F, and shall remain available for such uses until expended.

(c) The remainder of the amount to be available for obligation during the fiscal year, after deducting the amount of the President's budget estimates for the cost of administering this Act, shall from time to time be transferred from the general account to the health services account. Funds in the health services account shall be used exclusively for making payments for covered services in accordance with part E, and shall remain available for such payments until expended.

(d) As amounts available for a fiscal year for the administration of this Act are determined by the Congress, the amount available for the administration of the title shall be transferred from the general account to the administration account.

(e) From time to time any necessary adjustments shall be made in the amounts transferred to the several accounts, and in allocations previously made from the health services account.

REGIONAL ALLOCATIONS FROM HEALTH SERVICES ACCOUNT

SEC. 64. (a) For each fiscal year the Board shall, not later than June 1, next preceding the beginning of the fiscal year, make allocations to the regions of the Department from the funds to be available for the fiscal year in the health services account. The allocation to each region shall be equal to the estimated aggregate expenditures in the region for services, described in part B as covered services, in the most recent twelve-month period for which reliable data are available, adjusted to reflect the factors of change referred to in clauses (A), (B), and (C) of section 62(a)(2), and further adjusted in accordance with subsections (b) and (c) of this section.

(b) It shall be the objective of the Board to reduce gradually, and ultimately to eliminate substantially, existing differences among the regions of the Department in the average per capita cost of health services, except as such differences reflect differences in the prices of goods and services which enter into the cost of living for people in the several regions. To this end the Board shall modify the allocations for each fiscal year determined under subsection (a) in order (1) to reduce, or to lessen any increase in, the cost of covered services in regions in which the average per capita cost is higher (to an extent greater than the difference in the estimated weighted average cost of goods and services) than the national average per capita cost, to such an extent as the Board finds practicable without impairing materially the adequacy or quality of services to eligible persons, and (2) to stimulate, to such extent as the Board finds practicable and desirable, increases in the availability and utilization of covered services in regions in which the average per capita cost is lower (to an extent greater than the difference in the estimated weighted average cost of goods and services) than the national average per capita cost. In modifying allocations to the regions, the Board shall take account of regional differences in the composition of populations, in the prevalence and incidence of morbidity indicating need for covered services, in the available and needed resources in personnel or facilities for provision of covered services, in the costs of providing covered services, and in such other factors as the Board may deem pertinent, to the extent that such regional differences are not reflected in allocations under subsection (a) and have not already been taken into account, under this subsection, in modifying these allocations.

(c) The Board shall withhold from allocation to the regions a reserve for contingencies, in an amount not more than 5 per centum of the funds to be available for the fiscal year in the health services account. If the remaining amount to be available for the fiscal year in the account is less than the sum of the regional allocations determined pursuant to subsections (a) and (b), the allocations shall be reduced proportionately.

(d) Allocations under this section may be modified before or during a fiscal year if the amount to be available for obligation is modified pursuant to section 62 (c). The contingency reserve shall be available to increase one or more regional allocations, as the Board may find necessary. From the contingency reserve, or from additional funds in the general account made available for obligation, one or more allocations may also be increased if an epidemic, disaster, or other occurrence increases the need for health services to an extent which the Board finds requires the expenditure of additional funds.

DIVISION OF REGIONAL FUNDS BY CLASSES OF SERVICES

SEC. 65. (a) For each fiscal year the Board shall, not later than July 1, next preceding the beginning of the fiscal year, divide the allocation to each region into funds to be available, respectively, to pay the cost within the region of the following classes of services: (1) institutional services, (2) physician services, (3) dental services, (4) the furnishing of drugs, (5) the furnishing of devices, appliances, and equipment, and (6) other professional and miscellaneous services.

(b) The content, for purposes of the division of funds, of each class of services shall be defined in regulations. Within the funds to be available for miscellaneous services, the regulations shall establish subfunds, respectively, for the making of incentive payments not otherwise provided for, for supporting services described in section 27 (b), for payments to optometrists, for payments to podiatrists, for payments to independent pathology laboratories, for payments to independent radiology services, and for such other purposes as the Board may determine.

(c) The amounts assigned to the several funds and subfunds in each region shall be determined in accordance with regulations, which shall take into account, in addition to the factors considered in making the regional allocations, trends in utilization of the several services and, to the extent the Board finds it practicable, the creation of incentives to the improved utilization thereof.

FUNDS FOR HEALTH SERVICE AREAS

SEC. 66. (a) For each fiscal year the Board shall, not later than July 1, next preceding the beginning of the fiscal year, allot among the health service areas established in each region under section 124 (a), each of the funds established for the region pursuant to section 65 for a class of services. If an interstate health service area lies partly in each of two or more regions, appropriate allotments of funds from each region shall be made to it.

(b) The amount allotted to each health service area from each regional fund shall be equal to the aggregate expenditures in the area for services of the class for which the fund is to be available, as determined (or if necessary, estimated) by the Board for such twelve-month period as may be specified in regulations; modified to take account of the factors considered in making regional allocations and in dividing such allocations by classes of services (including modifications designed to further the objective of equalization within each region, in the manner set forth in section 64(b) with respect to interregional equalization).

(c) Payment for services, in accordance with part E, shall be made to participating providers in each health service area by such officer of the Board as it may designate for the purpose. There shall be established for each area such accounts as the Board may find convenient for making payment to providers of more than one class of services (such as an account for payment to hospitals, or an account for payment to group practice organizations), in which shall be deposited the appropriate portions of the funds for the several classes of services to be furnished by such providers.

MODIFICATION OF FUND ALLOTMENTS

SEC. 67. Before or during a fiscal year the division of funds by classes of services pursuant to section 65, or the allotment of funds to health service areas pursuant to section 66, may be modified if the regional allocations are modified, or if the Board finds that modification is required by events occurring or information acquired after the division and allotment were made.

INITIAL ACTIONS UNDER PART D

SEC. 68. In the determination of fund availability, regional allocations, and all other actions required by this part to be taken on a fiscal year basis, the Board may in its discretion take initial actions either for the three-month period between the effective date of health benefits and the beginning of the next fiscal year, or for the fifteen-month period between such effective date and the end of such fiscal year, making in either case appropriate adjustments in the amounts of such determinations, allocations, or other actions.

PART E—PAYMENT TO PROVIDERS OF SERVICES

IN GENERAL

SEC. 81. Payment shall be made to participating providers, in accordance with this part, for covered services furnished to eligible persons. Payments shall be made from the amounts allocated from the health services account in the Trust Fund, in accordance with part D, for the respective areas and purposes.

METHODS AND AMOUNT OF PAYMENT TO PROFESSIONAL PRACTITIONERS

SEC. 82. (a) Every independent professional practitioner shall be entitled, at his election, to be paid by the fee-for-service method, consisting of the payment of a fee for each separate covered service.

(b) Every physician engaged as an independent practitioner in the general or family practice of medicine (as determined in accordance with regulations under section 22 (b)), and every dentist engaged as an independent practitioner in the furnishing of covered dental services, shall be entitled, at his election, to be paid by the capitation method if he has filed with the Board an agreement (1) to furnish all necessary and appropriate primary medical services (as defined in such regulations) or covered dental services, as the case may be, to persons on a list of persons who have chosen to receive all such services from the practitioner, (2) to maintain arrangements for referral of patients to specialists, institutions, and other providers of covered services, and (3) to maintain such records and make such reports of services furnished as may be required by regulations for purposes of medical audit. A practitioner electing the capitation method is entitled to be paid by the fee-for-service method for services furnished to eligible persons who are not on his list, but not (except as provided in regulations) for specialized services furnished to persons who are on his list.

(c) When the Board deems it necessary in order to assure the availability of services or for other reasons, the Board (1) may pay an independent practitioner a full-time or part-time stipend in lieu of or as a supplement to the foregoing methods of compensation, and it may reimburse a practitioner for special costs of continuing professional education and of maintaining linkages with other providers of services (such as costs of communication and of attendance at meetings or consultations), and (2) may pay for specialized medical services a stated amount per session or per case or may utilize a combination of the methods authorized by this section.

(d) The capitation method of payment for a specified kind and scope of covered services consists of the payment to a provider of such services, of an annual capitation amount (determined for a health service area) for each person who has chosen to receive all such services from the provider.

(e) The amounts allotted for a fiscal year pursuant to part D for each health service area for physician services, for dental services, for optometrist services, and for podiatrist services, respectively, shall each be used (1) to provide for payments for professional services (made either directly to practitioners or as reimbursement to hospitals or other providers for the compensation of practitioners) to be made by the Board on a budget or stipend basis or any basis other than capitation, fee-for-service, or per case, and (2) from the remainder, to make available (for each kind of professional services) an equal per capita amount for each person resident in the area who is entitled to such services. In any area in which the Board finds that a substantial volume of services is furnished to nonresidents, it may reduce the per capita amount to such extent as it finds necessary to effect an equitable distribution of funds.

(f) The per capita amount shall constitute the annual capitation amount for purposes of payment to any organization, individual practice association, or other provider furnishing all covered services (described in part B) of the kind for which the allotment is available. Lesser capitation amounts shall be fixed, on the basis of the relative cost of the services, for primary medical services, and, as may be required, for any scope of services (less than comprehensive) which is furnished by any institutional or other provider. If the Board finds that the population served by a provider requires on the average, because of age distribution or other factor, a volume of services significantly greater or smaller than the average requirement of the population of the local health service area, the Board may, after consultation with the provider, make an appropriate adjustment in the capitation amount payable to him.

(g) For the compensation of professional practitioners who are to be paid by the Board (directly or through a delegation under this subsection) on a fee-for-service or per case basis, there shall be available—

(1) the per capita amount determined under subsection (e), multiplied by the number of residents of the health service area for whom no capitation payment (for services of the kind for which the allotment is available) is to be made under subsection (f),

(2) increased to reflect any excess resulting from a lowering of the per capita amount under subsection (e)

on account of services furnished to nonresidents, or from the fixing of lesser capitation amounts under subsection (f) for services less than comprehensive, and

(3) increased or reduced to reflect adjustments under subsection (f), on the ground of age distribution or other factor, in capitation amounts payable to other providers.

The amount of payments under this subsection shall be determined in accordance with relative value scales prescribed by the Board after consultation with representatives of the respective professions in the region, State, or area, and in accordance with unit values prescribed by the Board from time to time. The Board may, on such terms as it deems appropriate, delegate to a professional society or to an agency designated by representatives of a profession in the region, State, or area the payment of fees and per session amounts under this subsection.

(h) The Board may, on an experimental or demonstration basis, enter into an agreement with a statewide or local professional society or other organization representative of independent professional practitioners to substitute another method of compensation for those set forth in this section (either for all such practitioners, for all who have elected the fee-for-service method of payments, or for all who have elected another method), if the Board is satisfied that the substitute method will not increase the cost of services and will not encourage overutilization or underutilization of covered services. The Board shall review from time to time the operation of such an agreement, and shall, after reasonable notice, terminate it if the Board finds it to have led to increased cost or to overutilization or underutilization of covered services.

PAYMENT TO GENERAL HOSPITALS

SEC. 83. (a) A participating hospital (other than a psychiatric hospital) shall be paid its approved operating costs, determined in accordance with regulations, in the furnishing of covered services to eligible persons, as such approved costs for a fiscal year are set forth in a prospective budget approved by the Board. Regulations under this section shall specify the method or methods to be used, and the items to be included, in determining costs, and shall prescribe a nationally uniform system of cost accounting.

(b) The costs recognized in each hospital budget shall be those, determined in accordance with subsection (a), to be incurred in furnishing the covered services ordinarily furnished by the hospital to inpatients or outpatients, and in performing any other function ordinarily performed by the hospital and ordinarily financed from payments by or on behalf of patients (including the clinical aspects of education or training of professional or other health personnel), except as the scope of services or of other functions may be modified (1) by agreement of the Board and the hospital, (2) by application of guidelines for the clinical education or training of health personnel established pursuant to section 131 for the region or State in which the hospital is situated, or (3) by direction of the Board pursuant to section 134. The budget shall recognize any increase or decrease of cost resulting from a modification of the scope of services or of other functions, either by agreement or by direction of the Board.

(c) The costs recognized in the budget shall include the cost of reasonable compensation to (and other costs incident to the services of) pathologists, radiologists, and other physicians and other professional or nonprofessional personnel whose services are held out as generally available to patients of the hospital or to classes of its patients, whatever the method of compensation of such physicians and other personnel, and whether or not they are employees of the hospital.

(d) The Board shall review, through such of its officers or employees or through such boards, and in such manner, as may be provided in regulations, proposed budgets prepared and submitted to it by hospitals, and may provide for participation in such review by representatives of the hospitals in the region or health service area in which the hospital is situated. Each officer of the Board charged with final action on hospital budgets shall receive and consider written justifications of budget proposals, and may provide oral hearings thereon.

(e) A hospital budget approved under this section for a fiscal year may, in such manner as is provided in regulations, be amended before, during, or after the fiscal year if there is a substantial change in any of the factors relevant to budget approval.

(f) If a hospital (other than a psychiatric hospital) operates or has an affiliation agreement (described in section 52(b)) with a participating skilled nursing home, and also operates or has an agreement with a participating home health service agency, the Board may, on request of the institution or institutions and in accordance with regulations designed to reflect the cost of a combined operation, approve a consolidated budget and make all payments thereunder to the hospital.

PAYMENT TO PSYCHIATRIC HOSPITALS

SEC. 84. A participating psychiatric hospital which is primarily engaged in furnishing covered services shall be paid in the same manner as other hospitals. Any other participating psychiatric hospital shall be paid an amount determined in accordance with regulations for each patient day of covered services to an eligible person. Such regulations shall take into account, with respect to any distinct part of the hospital which meets the requirements of section 44, the factors to be considered in the approval of the budgets of hospitals other than psychiatric hospitals, but with such adjustments as are necessary to provide equitable compensation to the psychiatric hospital.

PAYMENT TO SKILLED NURSING HOMES AND TO HOME HEALTH SERVICE AGENCIES

SEC. 85. (a) A participating skilled nursing home or home health service agency shall be paid, in the same manner as a hospital (other than a psychiatric hospital), except as provided in subsection (b) of this section, its approved operating costs in the furnishing to eligible persons of skilled nursing home services or home health services, as the case may be.

(b) Regulations under this section shall, for skilled nursing homes and for home health service agencies, respectively, specify the method or methods to be used, and the items to be included, in determining costs; may, to the extent the Board deems desirable, specify nationally uniform systems of cost accounting; and, taking into account the prevailing practices of such homes or such agencies, may specify services which will be recognized in budgets and services which will not be so recognized.

PAYMENT FOR DRUGS

SEC. 86. (a) For each drug appearing on either of the lists established pursuant to section 25, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of the drug to a provider thereof. Product prices shall be so fixed as to encourage the acquisition of drugs in substantial quantities, and differing product prices for a single drug may be established only to reflect regional differences in cost or other factors not related to the quantity purchased.

(b) Payment for a drug furnished by an independent pharmacy shall consist of its cost to the pharmacy (not in excess of the applicable product price) plus a dispensing fee. The Board, after consultation with representatives of the pharmaceutical profession, shall establish (and from time to time review) schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of drugs dispensed, differences in services provided, and other factors which the Board finds relevant.

PAYMENT TO GROUP PRACTICE ORGANIZATIONS AND INDIVIDUAL PRACTICE ASSOCIATIONS

SEC. 87. (a) Payment to a group practice organization or to an individual practice association for covered services to its eligible enrollees shall consist of basic capitation payments plus additional payments (if any) determined in accordance with subsection (d).

(b) The basic capitation payment shall consist of a basic capitation amount multiplied by the number of eligible persons enrolled in the organization or association. The basic capitation amount shall be the sum of the appropriate capitation amount or amounts for professional services or class of services which it has undertaken to furnish.

(c) Capitation amounts for institutional services shall be based on per diem rates derived from the budgets (approved under this part) of participating institutional providers or, if the services are furnished through institutions operated by the group practice organization or individual practice association (or are furnished by contract with institutions which are not participating providers), derived from budgets prepared and approved in like manner as for participating institutions. Per diem rates shall be determined for each fiscal year, and for that year shall be modified only if the institutional budgets are amended or if modification is necessary to avoid substantial inequities.

(d) If it appears to the satisfaction of the Board (1) that the average utilization of hospital and skilled nursing home services by eligible persons enrolled in the organization or association (in whatever manner such services are provided) has, during a fiscal year, been less than the average utilization of such services under comparable circumstances by comparable population groups not enrolled either in group practice organizations or in individual practice associations, and (2) that the services provided by the organization or association have been of high quality and adequate to the needs of its enrollees, the Board shall make an additional payment to the organization or association equal to 75 per centum of the amount which the Board finds has been saved by such lesser utilization of hospital and skilled nursing home services. The amount of any such additional payment may be used by the organization or association for any of its purposes, including the application of such amounts to the cost of services not covered by this title.

(e) The Board shall, in accordance with regulations, make available to group practice organizations and individual practice associations, in consideration of premiums to be deducted from amounts otherwise payable to them under this section, insurance against (1) the cost, in excess of an amount fixed by the Board (which shall be not less than

$5,000), of services furnished during a calendar year to any one enrollee, (2) some or all of the cost of institutional services provided through arrangements with other participating providers in accordance with section 47(a)(5), and (3) some or all of the cost, for which the organization or association is responsible in accordance with section 47(a)(13), of services provided by other partipating providers. Premium rates for such insurance shall reflect the expected utilization of services by the enrollees of the organization or association insured.

(f) In addition to the payments required by this section, the Board may pay to a group practice organization the cost of clinical education or training provided by the organization (otherwise than in a hospital) which the Board finds to be in accordance with guidelines established pursuant to section 131 for the region or State in which the organization is situated.

PAYMENT TO OTHER PROVIDERS

SEC. 88. (a) An agency, organization, or other entity with which the Board has entered into an agreement under section 49(a) shall be paid by such method (other than the fee-for-service method) as, in accordance with regulations, may be set forth in the agreement.

(b) An independent pathology laboratory or an independent radiology service shall be paid on the basis of a budget approved by the Board, or on such other basis as may be specified in regulations.

(c) Payment for devices, appliances, and equipment, payment for ambulance or other covered transportation services, and payment for the services of a Christian Science sanatorium shall be made on such basis as may be specified in regulations.

REDUCTION IN PAYMENTS ON ACCOUNT OF UNNECESSARY CAPITAL EXPENDITURES

SEC. 89. Whenever the Secretary, pursuant to section 1122 of the Social Security Act (relating to reduction in Federal reimbursement in cases of unnecessary capital expenditures) issues a direction to the Board with respect to any health care facility owned or operated by a participating provider, the Board shall reduce accordingly amounts otherwise payable under this part to the provider.

METHODS AND TIME OF PAYMENT

SEC. 90. The Board shall periodically determine the amount which should be paid under this part to each participating provider of services (with adjustment for payments by one participating provider to another), and the provider shall be paid, from the health services account in the Trust Fund, at such time or times as the Board finds appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, the amount so determined, with adjustments on account of underpayments or overpayments previously made (including appropriate retrospective adjustments following amendment of approved institutional budgets). Payment may be made in advance in such cases and to such extent as the Board finds necessary to supply providers with working funds, on such terms as it finds sufficient to protect the interests of the United States.

PART F—DEVELOPMENT FUND

Subpart 1—Planning; Funds To Improve Services and To Alleviate Shortages of Facilities and Personnel

PURPOSES OF SUBPART 1

SEC. 101. (a) The purpose of this subpart is—

(1) prior to the effective date of health security benefits, to inaugurate a program of strengthening the Nation's resources of health personnel and facilities and its system of delivery of health services, in order to enable the providers of health services better to meet the demands on them when benefits under this title become available, and to that end to provide financial and other assistance (A) in alleviating shortages and maldistributions of health personnel and facilities in order to increase the supply of services, and (B) in improving the organi-

zation of health services in order to increase their accessibility and effective delivery; and

(2) after the effective date, to reinforce the operation of the health security program under this title as a mechanism for the continuing improvement of the supply and distribution of health personnel and facilities and the organization of health services, and to that end to assist in meeting those costs of improvement of personnel, facilities, and organization that are not met either through the normal operation of the health security program under this title or from other sources of public or private assistance.

(b) With respect to health facilities and the organization of health services, the Board shall be guided by the national health priorities established by section 1502 of the Public Health Service Act, the guidelines issued by the Secretary under section 1501 thereof, and State health plans which have been developed for the respective States and found by the Secretary to be adequate under title XV of that Act. Pending findings of adequacy of State health plans, the Board shall be guided by planning of the Secretary pursuant to section 102(a) of this Act.

(c) With respect to the education and training of health personnel, the Board shall be guided by planning of the Secretary pursuant to section 102 (b) of this Act.

PLANNING BY THE SECRETARY

SEC. 102. (a) Pending findings of adequacy of State health plans, the Secretary shall conduct within the Department studies addressed to identification of the most acute shortages and maldistributions of facilities and the most serious deficiencies in the organization for delivery of services covered under this Act, and of means for the speedy alleviation of these shortcomings. In carrying out this function, the Secretary shall consult with, and utilize the experience and recommendations of, existing State, regional, and local health planning agencies and State and local planning agencies and centers for health planning established pursuant to title XV of the Public Health Service Act.

(b) The Secretary shall have the continuing duty of planning for improvement of the supply and distribution of health personnel. He shall conduct such planning on a national, regional, State, or local basis as he may consider most appropriate for each kind of personnel, and in consultation with planning agencies referred to in subsection (a) to such extent as he deems desirable, and with appropriate professional organizations.

GENERAL POLICIES AND PRIORITIES

SEC. 103. (a) In providing assistance under this subpart, the Board shall give priority to improving and expanding the available resources for, and assuring the accessibility of, services to ambulatory patients which are furnished as part of coordinated systems of comprehensive care. To this end the Board shall encourage and assist (1) the development or expansion of group practice organizations meeting the requirements of section 47 (a), (2) the development or expansion of agencies, organizations, and centers described in section 49 (a) (1) or (2) to furnish services to persons in urban and rural areas who lack ready access to such services, (3) the recruitment and training of professional personnel to staff such organizations, agencies, and centers, (4) the recruitment and training of subprofessional and nonprofessional personnel (including the development and testing of new kinds of health personnel) to assist in the furnishing of such services, to engage in education for personal health maintenance, and to furnish liaison between such organizations, agencies, or centers and the people they serve, (5) the strengthening of coordination and linkages among institutional services (including linkages with educational institutions), among noninstitutional services, and between services of the two kinds, in order to improve the continuity of care and the assurance that patients will be referred to such services and at such times as may be medically appropriate, (6) the strengthening of coordination and cooperation between hospital medical staffs and hospital administrators, and (7) the inclusion of dental services in systems of comprehensive health care.

(b) Funds available to carry out this part shall not be used to replace other Federal financial assistance, or to supplement the appropriations for such other assistance except to meet specific needs of the health security program under this title (such as the training of physicians or medical students for the general or family practice of medicine). In administering other programs of Federal financial assistance the Secretary and other officers of the executive branch, on recommendation of the Board, shall to the extent possible utilize those programs to further the objectives of this part. To this end the Board, on such terms as it finds appropriate, may lend to an applicant or grantee not more than 90 per centum of the non-Federal funds required as a condition of assistance under any such program, and may pay all or part of the interest in excess of 3 per centum per annum on any loan made, guaranteed, or insured under any such program.

ORGANIZATIONS FOR THE CARE OF AMBULATORY PATIENTS

SEC. 104. (a) The Board is authorized to assist, in accordance with this section, the establishment, expansion, and operation of (1) group practice organizations which meet or will meet the requirements of section 47(a), (2) public or other nonprofit agencies, organizations, and centers described in section 49(a) (1) and (2), and (3) nonprofit organizations furnishing comprehensive dental services, which meet requirements set forth in regulations of the Board.

(b) The Board is authorized to make grants (1) to any public or nonprofit agency or organization (whether or not it is a provider of health services), for not more than 90 per centum of the cost (excluding costs of construction) of planning, developing, and establishing an organization or agency described in subsection (a) of this section; or (2) to an existing organization or agency described in subsection (a), for not more than 80 per centum of the cost (excluding costs of construction) of planning and developing an enlargement of the scope of its services or an expansion of its resources to enable it to serve more enrollees or a larger clientele. In addition to grants under this subsection, or in lieu of such grants, the Board is authorized to provide technical assistance for the foregoing purposes.

(c) The Board is authorized to make loans to organizations and agencies described in subsection (a) of this section to assist in meeting the cost of constructing (or otherwise acquiring, or improving or equipping) facilities which the Board finds will be essential to the effective and economical delivery, or to the ready accessibility, of covered services to eligible persons. No loan to a newly established agency or organization shall exceed 90 per centum and no loan to any other agency or organization shall exceed 80 per centum of such cost, or of the non-Federal share if other Federal financial assistance in meeting such cost is available.

(d) The Board is authorized to contract with an organization or agency which is described in subsection (a) of this section and which has been either newly established or substantially enlarged, to pay all or a part of any operating deficits, for not more than five years in the case of an organization described in subsection (a) (1), and until not later than the effective date of health security benefits in the case of an agency or organization described in subsection (a) (2) or (a) (3). Any such contract shall condition payments upon the contractor's making all reasonable effort to avoid or minimize operating deficits and (if such deficits exist) making reasonable progress toward becoming self-supporting.

RECRUITMENT, EDUCATION, AND TRAINING OF PERSONNEL

SEC. 105. The Board shall promptly establish (and from time to time review) schedules of priority for the recruitment, education, and training of personnel to meet the most urgent needs of the health security program. The schedules may differ for different parts of the United States.

(b) The Board is authorized to provide, to physicians and medical students, training for the general or family practice of medicine and training in any medical specialty in which the Board finds that there is, for the purpose of this title, a critical shortage of qualified practitioners.

(c) The Board shall provide education or training for those classes of health personnel (professional, subprofessional, or nonprofessional) for whom it finds the greatest need, if other Federal financial assistance is not available for such education or training; and if other assistance is available but the Board deems it inadequate to meet the increased need attributable to the health security program, it may, with the approval of the Secretary, provide such education or training pending action by the Congress on a recommendation promptly made by the Secretary to increase the authorization of appropriations (or, if the authorization is deemed adequate, to increase the appropriations for such other assistance).

(d) The training of personnel authorized by this section includes the development of new kinds of health personnel to assist in the furnishing of comprehensive health services, and also includes the training of persons to provide education for personal health maintenance, to provide liaison between the residents of an area and health organizations and personnel serving them, and to act as consumer representatives and as members of advisory bodies in relation to the operation of this title in the areas in which they reside. The Board may make grants to public or other nonprofit health agencies, institutions, or organizations (1) to pay a part or all of the cost of testing the utility of new kinds of health personnel, and (2) until the effective date of health security benefits, to pay a part of the cost of employing persons trained under this subsection who cannot otherwise readily find employment utilizing the skills imparted by such training.

(e) Education and training under this section shall be provided by the Board through contracts with appropriate educational institutions or such other institutions, agencies, or organizations as it finds qualified for this purpose. The Board may provide directly, or through the contractor, for the payment of stipends to students or trainees in amounts not exceeding the stipends payable under comparable Federal education or training programs.

(f) The Board shall undertake to recruit and train professional practitioners who will agree to practice, in urban or rural areas of acute shortage, in group practice organizations or in agencies, organizations, or centers referred to in section 49(a) (1) or (2). A practitioner who agrees to engage in such practice for at least five years and who enters upon practice in the area before the effective date of health benefits may until that date be paid a stipend to supplement his professional earnings, and in an appropriate case the Board may make a commitment to compensate the practitioner after that date in accordance with section 82(c).

(g) The Board shall undertake to recruit physicians to serve hospitals as their medical directors and to train such physicians (among other matters) in advising on and managing the development and implementation of medical policies and procedures and their coordination with planning and operational functions of the hospital, with its financing, and with its program of utilization review.

(h) In administering this section the Board shall seek to encourage the education and training, for the health professionals and other health occupations, of persons disadvantaged by poverty, inadequate education, or membership in ethnic minorities. To this end the Board may, through contracts in accordance with subsection (e), provide to such persons remedial or supplementary education preparatory to or concurrent with education or training for the health professions or occupations, and may (directly or through such contracts) provide to such persons stipends adequate to enable them to avail themselves of such education or training.

(i) Training which the Board is authorized by this section to provide shall include retraining, either to refresh and enhance skills of trainees for positions they already hold or to equip them for positions of greater responsibility.

SPECIAL IMPROVEMENT GRANTS

SEC. 106. (a) The Board is authorized to make grants to public or other nonprofit health agencies, institutions, and organizations to pay part or all of the cost of establishing improved coordination and linkages among institutional services (including linkages with educational institutions), among noninstitutional services, and between services of the two kinds.

(b) The Board is authorized to make grants to organizations, agencies, and centers described in section 104 (a) to pay part or all of the cost of installation of improved utilization review, budget, statistical, or records and information retrieval systems, including the acquisition of equipment therefor, or to pay part or all of the cost of acquisition and installation of diagnostic or therapeutic equipment.

LOANS UNDER PART F

SEC. 107. (a) Loans authorized under this part shall be repayable in not more than twenty years, shall bear interest at the rate of 3 per centum per annum, and (subject to the provisions of subsection (b)) shall be made on such other terms and conditions as the Board deems appropriate. Amounts paid as interest on any such loan or as repayment of principal shall, if the loan was made from funds appropriated pursuant to section 120(a), be covered into the Treasury as miscellaneous receipts, and if the loan was made from funds in the health resources development account, be deposited in the trust fund to the credit of that account.

(b) No loan for the construction or improvement of a facility shall be made under this part unless the borrower undertakes that all laborers and mechanics employed by contractors or subcontractors in the performance of construction or improvement on the project will be paid wages not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Davis Bacon Act (40 U.S.C. 276a–276a–5). The Secretary of Labor shall have with respect to the labor standards specified in this subsection the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix 133z–15) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

RELATIONS OF PARTS E AND F

SEC. 108. Payments by the Board under this subpart pursuant to any grant or loan to, or any contract with, a participating provider of services shall be made in addition to, and not in substitution for, payments to which the provider is entitled under part E.

SUBPART 2—PROGRAMS OF PERSONAL CARE SERVICES

PURPOSE OF SUBPART 2

SEC. 111. (a) The purpose of this subpart is to encourage and assist in the development of community programs for maintaining in their own homes, by means of comprehensive health and personal care services, persons who, by reason of disability or other health-related causes, would in the absence of such assistance require inpatient institutional services or might be expected to require such institutional services in the near future.

(b) It is the intent of the Congress that a grant under section 112 be made in any community to an eligible applicant which satisfies the Board that the applicant will be able (1) to develop, reasonably promptly, comprehensive services in accordance with this subpart, and (2) to develop non-Federal sources for the financing thereof to such extent as the Board finds appropriate in light of the economic resources of the community and resources otherwise available to it for this purpose.

GRANTS

Sec. 112. (a) The Board is authorized to make grants, for the development and conduct of programs in accordance with this subpart, to participating public or other nonprofit hospitals or group practice organizations, or to other public or nonprofit agencies or organizations which the Board finds qualified to conduct such programs. Each program shall be designed to serve a substantial population, defined in the grant, in either an urban or a rural community.

(b) A grant under this section may be made to pay a part or all of the estimated cost of a program (including startup cost) for a period of not more than four years, payable in such installments as the Board may determine, and may provide for meeting a decreasing share of the cost over the period of the grant. A grant shall be irrevocable except for nonperformance by the grantee or violation of the terms of this subpart or of the grant, or for other cause which would justify the termination or rescission of a contract. If it appears during the period of the grant that the cost of the program will exceed the estimate, the Board may increase prospectively the amount of the grant.

SCOPE OF SERVICES AND ELIGIBILITY THEREFOR

SEC. 113. (a) The services to be provided shall include, in addition to all covered health services (other than inpatient institutional services) described in part B (which may be provided by arrangement with participating providers), such groups or combinations of services as the Board deems necessary or appropriate to enable persons, found eligible for the services in accordance with subsection (b), to continue to live in their own homes or other noninstitutional places of residence. The personal care services may include homemaker and home help services, home maintenance, laundry services, meals-on-wheels and other nutrition services, assistance with transportation and shopping, and such other services as may be appropriate in particular cases. The Board may prescribe different ranges of services in different programs.

(b) For each program the Board shall prescribe criteria (consistent with section 111(a)) for the approval of the application for assistance, and such criteria may be different in different programs, but all programs shall be required to assure adequate coordination with all agencies in the community furnishing health or personal care services to beneficiaries of the program. Each grant shall require the grantee to establish, or arrange for the services of, a committee to screen applications for assistance under the program, in accordance with the applicable criteria, and no assistance shall be given until an application has been approved by the committee. The committee shall also maintain a constant review of utilization of the services provided by the program, and assistance to any person shall be terminated whenever the committee finds that he no longer meets the applicable criteria. The composition of the committee shall be subject to approval by the Board, and it shall include at least one physician, one professional nurse, one professional social worker, three representatives of the users of the services, and such other qualified persons as the Board may prescribe.

EVALUATION

SEC. 114. Each grant shall require the grantee to establish procedures for the evaluation of the program, with respect both to the benefits accruing to persons receiving assistance and to the fiscal impact of the program on the health security system. The Board shall also make its own evaluation of each program, and shall include a summary thereof in its annual report to the Congress.

RECOMMENDATIONS TO THE CONGRESS

SEC. 115. Before the end of the third calendar year after the enactment of this Act, the Board shall transmit to the Congress a comprehensive report on the operation of this subpart and the Board's evaluation of such operation, and shall submit its recommendation of (a) methods for the development, as widely and rapidly as practicable, of personal care services in communities lacking programs therefor or lacking adequate programs, to the end that such services in lieu of institutional care be made generally available throughout the United States, and (b) methods for the continuing financial support of such services; together with the Board's recommendations with respect to the proper role of the health security system in providing long-term institutional care and in providing personal care services in lieu thereof.

SUBPART 3—AVAILABILITY OF FUNDS

AUTHORIZATION OF APPROPRIATIONS; EXPENDITURES FROM TRUST FUND

SEC. 120. (a) For the purposes of this part there are hereby authorized to be appropriated $200,000,000 for the fiscal year beginning on July 1 of the year in which this title is enacted, and $400,000,000 for the succeeding fiscal year. Funds appropriated under this subsection shall remain available until expended.

(b) For the purposes of this part, the Board is authorized, after the effective date of health benefits, to make expenditures for the health resources development account in the Trust Fund, established pursuant to section 63.

Part G—Administration

ESTABLISHMENT OF THE HEALTH SECURITY BOARD

Sec. 121. (a) There is hereby established in the Department of Health, Education, and Welfare a Health Security Board to be composed of five members to be appointed by the President, by and with the advice and consent of the Senate. During his term of membership on the Board, no member shall engage in any other business, vocation, or employment. Not more than three members of the Board shall be members of the same political party.

(b) Each member of the Board shall hold office for a term of five years, except that (1) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of one, two, three, four, and five years, respectively, after the date of enactment of this Act. A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he has ceased to serve.

(c) The President shall designate one of the members of the Board to serve, at the will of the President, as Chairman of the Board.

DUTIES OF THE SECRETARY AND THE BOARD

SEC. 122. (a) The Secretary of Health, Education, and Welfare, and the Board under the supervision and direction of the Secretary, shall perform the duties imposed upon them, respectively, by this title. Regulations authorized by this title shall be issued by the Board with the approval of the Secretary, in accordance with the provisions of section 553 of title 5, United States Code (relating to the publication of, and opportunity to comment on, proposed regulations).

(b) The Board shall have the duty of continuous study of the operation of this Act and of the most effective methods of providing comprehensive personal health services to all persons within the United States and to United States citizens elsewhere, and of making, with the approval of the Secretary, recommendations on legislation and matters of administrative policy with respect thereto. The Board shall make, through the Secretary, an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to the effective date of health benefits, an evaluation by the Board of progress in preparing for the initiation of benefits under this title, and for periods thereafter, an evaluation of the operation of the title, of the adequacy and quality of services furnished under it, of the adequacy of compensation to providers of services, and of the costs of the services and the effectiveness of measures to restrain the costs.

(c) The Board shall from time to time conduct studies of the adequacy and equity of the financing of the national system of health security established by this Act and shall, with the approval of the Secretary, report its findings to the Congress, together with any recommendations for amendment of this Act or of the provisions of the Internal Revenue Code of 1954 pertaining to such financing. The first report under this subsection shall be submitted not later than two years after the effective date of health benefits, and thereafter reports shall be submitted at intervals not greater than four years.

(d) In performing his functions with respect to the Commission on the Quality of Health Care, and his functions with respect to health manpower education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, as well as in supervising and directing the administration of this title by the Board, the Secretary shall direct all activities of the Department toward mutually complementary contributions to the health of the people. He shall include in his annual report to the Congress a report on his discharge of this responsibility.

(e) The Secretary shall make available to the Board all information available to him, from sources within the Department or from other sources, pertaining to the functions of the Board.

(f) The Civil Service Commission, in consultation with the Board, shall to the greatest extent practicable facilitate recruitment, for employment by the Board in the competitive service, of qualified persons experienced in the administration or operation of private health insurance and health prepayment plans, or experienced in other fields pertinent to the administration of this title.

(g) The Secretary is authorized to establish on the staff of the Board, and to fix the compensation for, not more than fifty positions in the professional, scientific, and executive service, each such position being established to effectuate those research and development activities of the Board which require the services of specially qualified scientific, professional, and administrative personnel. The rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than the minimum rate of grade 16 of the General Schedule of the Classification Act of 1949, as amended, nor more than the highest rate of grade 18 of the General Schedule of such Act, and the rates of compensation for all such positions shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may designate for this purpose.

EXECUTIVE DIRECTOR; DELEGATION OF AUTHORITY

Sec. 123. (a) There is hereby established the position of Executive Director of the Health Security Board. The Executive Director shall be appointed by the Board with the approval of the Secretary, and shall serve as secretary to the Board and perform such duties in the administration of this title as the Board may assign to him.

(b) The Board is authorized to delegate to the Executive Director or to any other officer or employee of the Board or, with the approval of the Secretary (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department, any of its functions or duties under this title other than (1) the issuance of regulations, or (2) the determination of the availability of funds and their allocation, under sections 62, 63, and 64.

REGIONS AND HEALTH SERVICE AREAS

Sec. 124. (a) This title shall be administered by the Board through the regions of the Department (as they may be established from time to time) and, within each region, through health service areas. The areas shall be the same as the health service areas established by the Secretary under section 1511 of the Public Health Service Act, except that with the approval of the Secretary the Board may divide an area established under section 1511 into two or more areas for purposes of this title.

(b) The Board shall establish in each local health service area a local health security office and such branch offices as the Board may find necessary. The local offices and branch office, in addition to such informational and other administrative duties as the Board may assign them, shall have the function of receiving and investigating complaints by eligible persons and by providers of services concerning the administration of this title and of taking or recommending appropriate corrective action.

NATIONAL HEALTH SECURITY ADVISORY COUNCIL

SEC. 125. (a) There is hereby established a National Health Security Advisory Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and twenty members, not otherwise in the employ of the United States, appointed by the Secretary on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall include persons who are representative of providers of health services, and of persons (who shall constitute a majority of the Council) who are representative of consumers of such services. Each appointed member shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of members first taking office shall expire, as designated by the Secretary at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and five at the end of the fourth year after the date of enactment of this Act. Members of the Council who are representative of providers of health care shall be persons who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health personnel; members who are representative of consumers of such care shall be persons, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the furnishing of such services.

(b) The Advisory Council is authorized to appoint such professional or technical committees, from its own members or from other persons or both, as may be useful in carrying out its functions. The Council, its members, and its committees shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions. The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request by seven or more members it shall be the duty of the Chairman to call a meeting of the Council.

(c) It shall be the function of the Advisory Council (1) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations, and in the performance of the Board's functions under part D, and (2) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the title or in its provisions which may appear desirable. The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board through the Secretary, shall promptly transmit the report to the Congress, together resent professional, subprofessional, and nonprofessional per- Council for administrative action which have not been followed, and a report by the Secretary of his views with respect to any legislative recommendations of the Council.

(d) Appointed members of the Advisory Council and members of technical or professional committees, while serving on business of the Council (inclusive of traveltime), shall receive compensation at rates fixed by the Board, but not in excess of the daily rate paid under GS–18 of the general schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

REGIONAL AND LOCAL ADVISORY COUNCILS

SEC. 126. (a) The Board shall appoint for each of the regions of the Administration and for each health service area a regional or local advisory council, consisting of the regional or local representative of the Board as chairman and (in such numbers as the Board may determine) representatives of providers of health services and representatives (who shall constitute a majority of the members of each council) of consumers of such services. So far as possible, representatives of providers shall be so selected as to represent professional, subprofessional, and nonprofessional personnel, and representatives of consumers shall be so selected as to represent the major segments of the population to be served. Each council shall meet as often as its members may decide, but in no event less than four times each year. It shall be the function of each such council to advise the regional or local representative of the Board, as the case may be, on all matters directly relating to the administration of this title in the region or area, including methods and procedures followed in the handling of complaints.

(b) The provisions of section 125(d) shall be applicable to the members of councils appointed under this section.

PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEES

SEC. 127. (a) The Board shall appoint such standing professional and technical committees as it deems necessary to advise it on the administration of this title with respect to the several classes of covered services described in part B. Each such committee shall consist of experts (in such numbers as the Board may determine) drawn from the health professions, from medical schools or other health educational institutions, from providers of services, or from other sources, whom the Board deems best qualified to advise it with respect to the professional and technical aspects of the furnishing and utilization of, the payment for, and the evaluation of, a class of covered services designated by the Board, and with respect to the relationship of that class of services to other covered services.

(b) The Board is authorized to appoint such experts and consultants (employed in accordance with section 3109 of title 5, United States Code), and to appoint such temporary professional and technical committees, as it deems necessary to advise it on special problems not encompassed in the assignments of standing committees appointed under subsection (a), or to supplement the advice of standing committees.

(c) In connection with its duties under section 122 (c), the Board is authorized to appoint such standing or temporary committees of fiscal, actuarial, and other experts as it deems necessary.

(d) Committees appointed under this section shall report from time to time to the Board, and copies of their reports shall be transmitted by the Board to the National Advisory Council.

(e) The provisions of section 125 (d) shall be applicable to experts and consultants and to the members of committees appointed under this section.

PARTICIPATION BY STATE AGENCIES

SEC. 128. (a) The Board shall consult from time to time with State health agencies (including agencies established pursuant to title XV of the Public Health Service Act) or other appropriate State agencies in preparing for and in administering health security benefits, with a view to coordinating the administration of this title with State and local activities in the fields of health planning, environmental health, licensure and inspection, education for the health professions and other health careers, and other fields relating to health. Insofar as practicable, the Board shall conduct such consultation through the regional offices of the Administration.

(b) The Board shall make an agreement with any State which is able and willing to do so under which the State health agency or other appropriate State agency will be utilized by the Board in determining whether providers of services meet or continue to meet the qualifications and requirements established by or pursuant to part C or part H. Such an agreement shall fix the frequency of inspection of the several classes of providers, other than professional practitioners, and shall establish the qualifications required of persons making the inspections. Determinations by State agencies based upon inspections made in accordance with such agreements, and determinations with respect to professional practitioners, may be given by the Board the same effect as determinations by the Board.

(c) An agreement under subsection (b) may provide that a State agency, either directly or through local public agencies, will undertake activities, specified in the agreement, directed to the health education of the residents of the State, the maintenance and improvement of the quality of covered services furnished in the State, the maintenance of effective utilization review, or the better coordination of services of different kinds.

(d) The Board shall pay to a State, in advance or otherwise as specified in the agreement, the reasonable cost of services and activities pursuant to an agreement under this section; and may pay a part or all of the cost of training (or may train) State personnel to enable them to meet the qualifications established by the Board for inspectors.

(e) In any State which is unable or unwilling to make inspections in accordance with subsection (b), the Board shall make such inspections either through its own personnel or through contract with an organization or organizations which it finds qualified to perform this function.

(f) Within ninety days after the completion of an inspection of any provider under subsection (b) or subsection (e), the Board shall make public in readily available place and form the findings of such inspection which pertain significantly to compliance with the qualifications and requirements established by or pursuant to part C or part H; except that if the State agency or the Board, on the basis of such inspection, has made a determination respecting compliance by the provider, the publication shall be based on such determination.

TECHNICAL ASSISTANCE TO SKILLED NURSING HOMES AND HOME HEALTH SERVICE AGENCIES

SEC. 129. The Board is authorized, either directly or through agreements with State agencies under section 128, to provide technical assistance to skilled nursing homes and home health service agencies to supplement, in regard to social services, dietetics, and other matters, the skills of the groups referred to in sections 45 (b) and 46 (b).

DISSEMINATION OF INFORMATION; STUDIES AND EVALUATIONS; SYSTEMS DEVELOPMENT; TESTS AND DEMONSTRATIONS

SEC. 130. (a) The Board shall disseminate, to providers of services and to the public, information concerning the provisions of this title, the persons eligible to receive the benefits of the title, and the nature, scope, and availability of covered services; and to providers of services, information concerning the conditions of participation, methods and amounts of compensation to providers, and other matters relating to their participation. With the approval of the Secretary, the Board may furnish to all professional practitioners information concerning the safety and efficacy of drugs appearing on either of the lists established under section 25, the indications for their use, and contraindications.

(b) The Board shall make, on a continuing basis after the effective date of health security benefits, a study and evaluation of the operation of this title in all its aspects, including study and evaluation of the adequacy and quality of services furnished under the title, analysis of the cost of each kind of services, and evaluation of the effectiveness of measures to restrain the costs.

(c) The Board is authorized, either directly or by contract—

(1) to make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this title, including studies of the effect of the title upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(2) to develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(3) to develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of health services, and equipment (such as equipment for the monitoring of patients' functions, or for multiphasic screening) useful in the furnishing of preventive or diagnostic services;

(4) to develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of

independent pharmacies for the cost of furnishing drugs as a covered service; and

(5) to make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this title.

(d) The Board is authorized to develop, and to test and demonstrate through agreements with providers of services or otherwise, methods designed to achieve, through additional incentives or in any manner, improvement in the coordination of services furnished by providers, improvement in the adequacy, quality, or accessibility of services, or decrease in their cost; methods of peer review and peer control of the utilization of drugs, laboratory services, and other services not subject to utilization review under section 51; and methods of peer review of quality. Agreements with providers for tests or demonstrations may provide for alternative methods of reimbursement in lieu of methods prescribed by part E, but, in the case of independent professional practitioners, only in accordance with section 82 (h).

GUIDELINES FOR HEALTH MANPOWER EDUCATION AND TRAINING

SEC. 131. The Board shall make a continuing evaluation of the adequacy of the various classes of professional and health personnel to furnish services under this title and, after consultation with national and other organizations concerned with education and training of such personnel, and with the approval of the Secretary, shall from time to time issue guidelines designed to relate the clinical education and training conducted by providers of services more closely to the relative need for the several classes of such personnel. The guidelines shall seek to further national health manpower objectives, but shall be adapted for each region or State to take account of the capacity of providers to conduct such clinical education or training, and (to the extent the Board deems appropriate) to take account of any special manpower needs within the region or State.

DETERMINATIONS; SUSPENSION OR TERMINATION OF PARTICIPATION

SEC. 132. (a) Determinations of entitlement to benefits under this title, determinations of who are participating providers of services, determinations whether services are covered services, and determinations of amounts to be paid by the Board to participating providers, shall be made by the Board in accordance with regulations. A provider or other person aggrieved by a determination under this subsection shall, in such cases and on such conditions as are specified in regulations, be entitled to an administrative appeal from it.

(b) If the Board finds that a participating provider of services no longer meets the qualifications and requirements established by or pursuant to part C and subpart 1 of part H for services of the kinds furnished by him, or for some classes of such services, or that he has intentionally violated the provisions of this title or of regulations, or that he has failed substantially to carry out the agreement filed by him pursuant to section 41 (a) (3), the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the provider, or suspending or terminating it with respect to particular classes of services.

(c) If the Board has reason to believe that a participating professional practitioner, or a professional practitioner furnishing covered services on behalf of an institutional or other participating provider, has in a substantial number of cases—

(1) furnished professional services, or caused the furnishing of institutional or other services, which were not medically necessary but for which payment was claimed under this title,

(2) furnished to eligible persons covered services which were not of a quality meeting professionally recognized standards of care, or

(3) neglected to furnish necessary services to eligible persons who were his patients, under circumstances

such that the neglect constituted a breach of his professional obligation,

or has reason to believe that a participating provider other than a professional practitioner has in a substantial number of cases—

(4) furnished services, for which payment was claimed under this title, known to the provider not to be medically necessary, or

(5) furnished to eligible persons covered services which were not of a quality meeting professionally recognized standards of care,

the Board shall submit the evidence in its possession either to an appropriate professional organization or to a committee constituted by the Board after consultation with such an organization (which committee may, when the Board deems it proper, include nonprofessional persons). The Board shall request the organization or committee, with or without further investigation, to recommend what action, if any, should be taken by the Board. Taking into consideration any recommendation so made to it, the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the practitioner or other provider or, in the case of a practitioner furnishing services on behalf of another provider, requiring the other provider, as a condition of continued participation, to suspend or discontinue (absolutely or on conditions) the furnishing of covered services by the practitioner.

(d) The Board shall, either in advance or by way of reimbursement, pay to an organization or committee making a recommendation under subsection (c) its reasonable cost incurred in so doing.

(e) No determination under subsection (a) that a person, previously determined to be eligible for benefits, is not eligible therefor, and (unless the Board finds that eligible persons are endangered) no order under subsection (b) or (c), shall be effective until after the person or provider has been afforded a hearing under section 133 or an opportunity therefor.

HEARINGS: JUDICIAL REVIEW

SEC. 133. (a) A provider of services or other person who is dissatisfied with a determination made or an order issued under section 132 shall, upon request therefor filed in accordance with regulations, be entitled to a hearing before a hearing officer or a hearing panel of the Board. The hearing shall be held as promptly as possible and at a place convenient to the provider or other person requesting the hearing. For the purpose of reviewing the determinations of hearing officers or panels, the Board shall establish appeals tribunals (which may include regional or other intermediate appeals tribunals), and shall by regulation prescribe the jurisdiction of such and procedures for appeal to them. Decision of hearing officers or hearing panels shall, subject to appeals under this subsection, constitute final decisions to the Board.

(b) In any case in which the Board finds (on the basis of the request for hearing and the records of the Board) that a substantial issue of professional practice or conduct, in a health profession specified for this purpose in regulations, will be involved in the hearing, the hearing shall be held either before a person who is qualified in an appropriate health profession or before a panel which includes a person or persons so qualified, and an appeal in such a case shall be heard before an appellate tribunal (or a panel thereof) which includes a person or persons so qualified. In any case in which a single person qualified as a health professional, or a panel composed entirely of persons so qualified, conducts a hearing or hears an appeal, the Board shall assign an attorney to assist in the conduct of the hearing or the appeal and to advise upon the decision of issues of law.

(c) (1) Any provider of services or other person, after any final decision of the Board made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Board may allow. Such action shall be brought in the district court of the United States, for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia. As part of its answer the Board shall file a certified copy of the transcript of the record, including the evidence upon which the findings and decision complained of are based.

(2) The Court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Board, with or without remanding the cause for a rehearing. The findings of the Board as to any fact, if supported by substantial evidence, shall be conclusive.

(3) Where a claim has been denied by the Board, or a decision is rendered which is adverse to a provider or other person who was a party to the hearing before the Board, because of failure of the claimant or such provider or other person to submit proof in conformity with any regulation prescribed by the Board, the court shall review only the question of conformity with the regulation and the validity of the regulation. The court shall not review a find-

ing by the Board under subsection (b), or a refusal to find, that a substantial issue of professional practice or conduct will be involved in a hearing.

(4) The court shall, on motion of the Board made before it files its answer, remand the case to the Board for further action by the Board, and may, at any time on good cause shown, order additional evidence to be taken before the Board. The Board shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm its findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision and a transcript of the additional record and testimony. Such additional or modified findings of fact and decision shall be reviewable only to the same extent as the original findings of fact and decision.

(5) The judgment of the court shall be final except that it shall be subject to review in the same manner as judgments in other civil actions.

DIRECTIONS BY THE BOARD FOR THE BETTER ORGANIZATION AND COORDINATION OF SERVICES

SEC. 134. (a) The Board is authorized, in accordance with this section, to issue to any participating provider of services (other than an individual professional provider) a direction that the provider shall—

(1) discontinue (for the purposes of payment under part E) one or more services which the provider is currently furnishing;

(2) initiate one or more covered services which the provider is not currently furnishing;

(3) initiate the furnishing of one or more covered services at a place where the provider is not currently furnishing the services; or

(4) enter into arrangements with one or more other providers of services (A) for the transfer of patients and medical records as may be medically appropriate, (B) for making available to one provider the professional and technical skills of another, or (C) for such other coordination or linkage of covered services as the Board finds will best serve the purposes of this title.

A direction under this subsection shall specify a future date on which, if the direction has not been complied with, the provider to whom it is addressed shall cease to be a participating provider.

(b) If the Board finds (1) that the services furnished by a provider of services (other than an individual professional provider) are not necessary to the availability of adequate services under this title and that their continuance as covered services is unreasonably costly, or (2) that the services are furnished inefficiently and at unreasonable cost, that effort at correction has proved unavailing, and that necessary services can be more efficiently furnished by other providers, the Board may issue a direction that on a specified date the provider shall cease to be a participating provider.

(c) No direction shall be issued under this section except on the recommendation of, or after consultation with, the State health planning and development agency (if such an agency has been established pursuant to title XV of the Public Health Security Act) of the State in which the direction will be operative. No direction shall be issued under subsection (a) unless the Board finds that it can practicably be carried out by the provider to whom it is addressed.

(d) (1) No direction shall be issued under this section until the Board has published notice, in the service area of the provider or providers affected, describing in general terms the proposed action, giving a brief statement of the reasons therefor, and inviting written comment thereon. The notice shall be published in at least one newspaper circulating in the area, and the Board shall use such other means as it finds calculated to inform residents of the area of the proposed action.

(2) If objection to the proposal is made by any interested provider of services (other than an individual profes-

sional practitioner) or by an interested health planning agency or by a substantial number of interested professional practitioners or of residents of the area, the Board shall call a public hearing before a hearing officer or hearing panel meeting the requirements of section 133 (b). At the hearing the Board shall present evidence in support of the proposal, and any interested provider of services or health planning agency or any other interested person shall be entitled to participate in the hearing and to present evidence or argument or both. On the basis of evidence presented at the hearing, the hearing officer or hearing panel shall make recommended findings of fact and a recommended determination either to issue the proposed direction, to modify and issue it, or to withdraw the proposal. The final determination shall be made by the Board or by a special panel designated by it for the purpose, and shall be subject to judicial review in accordance with section 133 (c).

PART H—QUALITY OF CARE

PURPOSE AND GENERAL POLICIES

SEC. 141. (a) The Board, with the advice and assistance of the Commission on the Quality of Health Care (established by section 1701 of the Public Health Service Act), shall have the continuing responsibility to maintain and enhance the quality of health care furnished under this Act, and to that end shall:

(1) prior to the effective date of health benefits, issue regulations authorized by this part, (A) to supplement the qualifications required by part C of providers of services as a condition of participation, and (B) to strengthen existing mechanisms for the control and enhancement of quality; and

(2) thereafter continuously review such regulations with a view to (A) upgrading such requirements as rapidly as the Board finds practicable, and (B) developing recommendations to the Congress for amendments of this Act designed further to assure and enhance the quality of care.

(b) In discharging its responsibility under this part, it shall be the objective of the Board to require the highest practicable quality of care that is attainable in substantially all parts of the United States. Exceptions to requirements under this part shall be permitted only when necessary to avoid critical shortages of services, and shall be reviewed from time to time and shall be eliminated whenever, and as soon as, the Board finds it practicable to do so.

(c) The Board shall assist the Commission on the Quality of Health Care in obtaining reports and information required for the purposes of the Commission, and the Commission shall advise the Board in the development and issuance of regulations under this part and in the development of recommendations to the Congress. If the Board fails to adopt, by regulation issue under this part, a standard which the Commission has recommended be so adopted, the matter shall be reported to the Secretary and, unless he directs the Board to follow the recommendations of the Commission, the Board shall publish a statement of the recommendation and of its reasons for failing to adopt the standard.

CONTINUING PROFESSIONAL EDUCATION

SEC. 142. (a) Not later than two years after the effective date of health benefits, the Board shall by regulation establish for physicians, dentists, optometrists, and podiatrists such requirements of continuing education (taking into consideration standards approved by appropriate professional organizations) as it finds reasonable to maintain and enhance the quality of professional services furnished under this Act.

(b) Regulations under this section shall require the filing of such periodic reports as the Board finds necessary to assure that participating practitioners, and practitioners furnishing services on behalf of participating institutional and other providers, are in compliance with requirements established under subsection (a). The Board shall give warning to any practitioner whom such reports show to have failed to comply substantially with the requirements, and, before taking action under section 132 (b), shall afford him an opportunity to explain or correct the deficiency.

MAJOR SURGERY AND OTHER SPECIALIZED SERVICES

SEC. 143. (a) Major surgery and other specialized services designated in regulations are not covered services unless they are furnished by specialists and, to the extent specified in regulations, are either emergency services or services furnished on referral by a physician engaged in general or family practice (as determined in accordance with regulations under section 22 (b)).

(b) A physician is a specialist, for the purposes of subsection (a), only if he holds a certificate from the appropriate national specialty board; except that (1) a physician who possesses the qualifications requisite to such certification may furnish services as a specialist during a period of five years after attaining such qualifications (or, if later, after the effective date of health benefits), and (2) a physician may be authorized by the Board to furnish services as a specialist if (A) prior to the effective date he has engaged in furnishing such services as a specialist or as a substantial part of his medical practice, (B) he meets standards established by the Board, and (C) where appropriate, authorization to him to furnish services as a specialist is recommended by a participating hospital in which he has engaged substantially in furnishing such services.

(c) The Board may by regulation exclude from covered services specified surgical procedures, when not required by life threatening or other acute emergencies, which have not been preceded by consultation with, and recommendation of surgery by, such appropriately qualified specialists as may be required by the regulations. Hospital and other services incident to surgery excluded by regulations under this subsection are not covered services.

(d) With respect to the performance of surgical procedures specified in regulations under subsection (c), including emergency procedures, the Board may require as a condition of payment to the provider that there be submitted to the Board a pathology report on tissue removed and a clinical abstract or discharge report of the case.

ADDITIONAL REQUIREMENTS FOR PARTICIPATION

SEC. 144. (a) No provider on whose behalf one or more physicians, dentists, optometrists, or podiatrists furnish professional services described in section 22 or section 23 or in regulations issued under section 27(a) (1) or (2) shall be a participating provider unless every practitioner furnishing such services is a qualified provider in accordance with section 42 and meets such requirements, applicable to practioners of his profession, as are prescribed by or pursuant to this part.

(b) The Board may by regulation establish, as conditions of participation by providers other than independent professional practitioners, requirements (additional to those specified in part C and those otherwise prescribed by or pursuant to this part) which the Board finds necessary in the interest of the quality of care and the safety of eligible persons. In establishing requirements under this subsection, the Board shall take into consideration standards or criteria established or recommended by appropriate professional or other associations or organizations. The Board shall establish such requirements as it finds necessary to assure that participating hospitals and skilled nursing homes meet the requirements prescribed from time to time for accreditation by the Joint Commission on the Accreditation of Hospitals, but the authority of the Board is not limited to the requirements of the Joint Commission. Exceptions to requirements established under this subsection shall be permitted only in accordance with section 141 (b).

PROFESSIONAL STANDARDS REVIEW AND SIMILAR ORGANIZATIONS

SEC. 145. On recommendation of the Commission on the Quality Health Care, the Board may contract with a Professional Standards Review Organization heretofore designated or conditionally designated as such by the Secretary, or with an organization performing similar functions hereafter approved for the purpose by the Board, to monitor the quality of some or all institutional and other services furnished under this Act within the area of operation of such organization, and to report to the Board its findings with respect to conformity to the requirements relating to quality prescribed by or pursuant to this Act. Any such contract shall be so designed as to supplement, and not duplicate, inspections by State agencies under section 128 (b) or by the Board under section 128 (e). The Board shall pay to the organization, in advance or otherwise as specified in the contract, the reasonable cost of services and activities of the organization under the contract.

FINDINGS OF COMMISSION ON MEDICAL MALPRACTICE

SEC. 146. In exercising its authority under this part the Board shall give consideration to the findings, report, and recommendations of the Commission on medical malpractice established by the Secretary, and within the authority conferred by this or any other Act shall put into effect such of the recommendations of that Commission and such other measures as in the judgment of the Board will tend to reduce the incidence of malpractice, to lessen the cost or increase the availability of malpractice insurance, or to facilitate the speedy, equitable, and economical adjudication of malpractice claims.

PART I—MISCELLANEOUS PROVISIONS

DEFINITIONS

SEC. 161. When used in this title—

(a) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(b) The term "United States" when used in a geographical sense means the States, as defined in subsection (a).

(c) The term "Secretary", except when the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(d) The term "Department", except when the context otherwise requires, means the Department of Health, Education, and Welfare.

(e) The term "Board" means the Health Security Board established by section 121.

DEPUTY SECRETARY OF HEALTH, EDUCATION, AND WELFARE; UNDER SECRETARY FOR HEALTH AND SCIENCE

SEC. 162. (a) There shall be in the Department of Health, Education, and Welfare, in addition to the Assistant Secretaries now provided for by law, a Deputy Secretary of Health, Education, and Welfare and an Under Secretary for Health and Science each of whom shall be appointed by the President, by and with the advice and consent of the Senate, and shall perform such functions (related to health and science, in the case of such Under Secretary) as the Secretary may prescribe. The provisions of the second sentence of section 2 of Reorganization Plan Numbered 1 of 1953 shall be applicable to such Deputy Secretary to the same extent as they are applicable to the Under Secretary of Health, Education, and Welfare and shall be applicable to the Under Secretary for Health and Science to the same extent as they are applicable to the Assistant Secretaries authorized by that section.

(b) (1) The office of Under Secretary of Health, Education, and Welfare, created by section 2 of Reorganization Plan Numbered 1 of 1953 (67 Stat. 631), is hereby abolished.

(2) The President may authorize the person who immediately prior to the date of enactment of this Act occupies the office of Under Secretary of Health, Education, and Welfare to act as Deputy Secretary of Health, Education, and Welfare until that office is filled by appointment in the manner provided by subsection (a) of this section. While so acting, such person shall receive compensation at the rate now or hereafter provided by law for the Deputy Secretary of Health, Education, and Welfare.

SEC. 163. The effective date of health security benefits under this title shall be July 1 of the second calendar year after the year in which this title is enacted, and no service or item furnished prior to that date shall constitute a covered service. Section 406, transferring and amending section 1817 of the Social Security Act and redesignating it as section 61 of this Act, shall be effective on the effective date of health benefits, and part D (including section 61) shall be effective with respect to fiscal years beginning on or after that date. In all other respects this title shall be effective upon enactment, and appropriations for the purposes of this title (including action pursuant to section 201 (g) of the Social Security Act, as amended by section 406 of this Act, to make funds available on and after the effective date of health benefits) are authorized to be made prior to the effective date of health benefits.

EXISTING EMPLOYER-EMPLOYEE HEALTH BENEFIT PLANS

SEC. 164. (a) No provision of this Act other than this section, and no amendment of the Internal Revenue Code of 1954 made by this Act, shall affect or alter any contractual or other nonstatutory obligation of an employer to pay for or provide health services to his present and former employees and their dependents and survivors, or to any of such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the costs of such services.

(b) Any contractual or other nonstatutory obligation of the employer to pay all or part of the cost of the health services referred to in subsection (a) shall continue, and shall apply as an obligation to pay the taxes imposed on his employees by section 3101 (b) of the Internal Revenue Code of 1954 (as amended by section 201 (a) of this Act), but the sum of the per capita monthly amount involved in the payment of such taxes by the employer on behalf of his employees, and the per capita amount of the liability for taxes imposed on an employer by section 3111 (b) of such Code (as amended by section 201 (b) of this Act) shall not exceed the per capita monthly amount of the cost to the employer of providing or paying for health services (either through insurance premiums or into a fund) on behalf of persons referred to in subsection (a), for the month prior to the effective date of health security taxes (as defined in section 3121 (u) of such Code, added by section 201 (c) of this Act.)

(c) At least for the duration of any contractual or other nonstatutory obligation of an employer referred to in subsection (a), an employer shall arrange to pay to eligible employees, former employees, and survivors referred to in subsection (a) such amounts of money by which the per capita monthly costs to the employer of providing or paying for health services referred to in subsection (a) in the month immediately preceding the effective date of health security taxes, exceed the sum of the per capita monthly costs to the employer of the taxes imposed by section 3111 (b) of such Code (as amended by section 201 (b) of this Act), the employer's liability referred to in subsection (b) of this section, and any other employer contributions for health insurance premiums or health benefits or services provided by the employer after the effective date of health security benefits. By agreement between the employer and his employees or their representatives, an employer may provide other benefits of an equivalent monetary value in lieu of such payments.

(d) For purposes of subsections (b) and (c), the per capita amounts and per capita costs for an employer shall be determined by dividing the aggregate amounts and the aggregate costs by the number of eligible employees, former employees, and survivors on the date as of which the determination is made.

TITLE II—HEALTH SECURITY TAXES

Part A—Employment Taxes

RATE AND COVERAGE

Sec. 201. (a) Section 3101 (b) of the Internal Revenue Code of 1954 (imposing a hospital insurance tax on employees) is amended to read as follows:

"(b) Health Security.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 1 percent of the wages (as defined in section 3121 (r)) received by him on or after the effective date of health security taxes (as defined in section 3121 (u)) with respect to employment (as defined in section 3121 (s)) ."

(b) Section 3111 (b) of such Code (imposing a hospital insurance tax on employers) is amended to read as follows:

"(b) HEALTH SECURITY.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 3.5 percent of the wages (as defined in section 3121 (r)) paid by him on or after the effective date of health security taxes (as defined in section 3121 (u)) with respect to employment (as defined in section 3121 (s)) ."

(c) Section 3121 of such Code (containing definitions applicable to social security payroll taxes) is amended by adding at the end thereof the following subsections:

"(r) WAGES FOR PURPOSES OF HEALTH SECURITY TAXES.—For the purpose of section 3101 (b), and for the purpose of section 1402 (b) as applied to section 1401 (b), the term 'wages' shall have the meaning set forth in subsection (a) of this section (as that subsection would apply to employment as defined in subsection (s)), except that in applying paragraph (1) of subsection (a) the term 'the health security contribution base (as defined in subsection (t))' shall be substituted for the term 'the contribution and benefit base (as determined under section 230 of the Social Security Act)' each place it appears therein. For the purpose of section 3111(b), the term 'wages' shall have the same meaning, except that paragraph (1) of subsection (a) shall not be applied.

"(s) EMPLOYMENT FOR PURPOSES OF HEALTH SECURITY TAXES.—For the purposes of sections 3101(b) and 3111(b), the term 'employment' shall have the meaning set forth in subsection (b) of this section except that—

"(1) clause (B) preceding paragraph (1) of subsection (b) shall not be applied to an employee whose principal post of duty is outside the United States;

"(2) the exclusions contained in the following paragraphs of subsection (b) shall not be applied: paragraph (1) (relating to foreign agricultural workers), paragraphs (5) and (6) (relating to employment by the United States or its instrumentalities) other than paragraph (6)(C)(i) (relating to the President, the Vice President, and Members of Congress) and paragraph (6)(C)(iii) through (v) (relating to certain minor employments), paragraph (8) (relating to employment by charitable and similar organizations), paragraph (9) (relating to employment covered by the railroad retirement system), and paragraph (17) (relating to employment by subversive organizations);

"(3) subsection (m) of this section (including services by members of the uniformed services in the term 'employment') shall not be applied; and

"(4) for the purpose of section 3101(b), the exclusion contained in paragraph (7) of subsection (b) of this section (relating to employment by States and their political subdivisions and instrumentalities) shall not be applied, other than paragraph (7)(C)(i) through (iv) (relating to certain minor employments by the District of Columbia).

"(t) HEALTH SECURITY CONTRIBUTION BASE.—The term 'health security contribution base' means, for any calendar year, 150 percent of the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for such calendar year."

"(u) EFFECTIVE DATE OF HEALTH SECURITY TAXES.—The term 'effective date of health security taxes' means January 1 of the second calendar year after the year in which the Health Security Act is enacted."

CONFORMING AND TECHNICAL AMENDMENTS

SEC. 202. (a) Section 3121(1) of the Internal Revenue Code of 1954 (relating to coverage of services performed in the employ of foreign subsidiaries of domestic corporations) is amended by striking out "sections 3101 and 3111" in paragraph (1)(A) and inserting in lieu thereof "sections 3101 (a) and 3111 (a)", and by inserting at the end of the subsection the following paragraph:

"(11) Notwithstanding the provision of any agreement entered into under this subsection, no domestic corporation shall be under any obligation to pay the Secretary, with respect to services covered under the agreement and performed on or after the effective date of health security taxes (as defined in subsection (u) of this section) amounts equivalent to the taxes which would be imposed by setcions 3101 (b) and 3111 (b) if such services constituted employment as defined in subsection (b) or subsection (s)."

(b) Sections 3122 and 3125 of such Code are amended by striking out "section 3111" wherever it appears and inserting in lieu thereof "section 3111 (a)".

(c) (1) Section 3201 (relating to tax on railroad employees) and section 3211 (relating to tax employee representatives) of such Code are each amended by striking out "plus the rate imposed by section 3101 (b)."

(2) Section 3221 (b) of such Code (relating to tax on railroad employers) is amended by striking out "plus the rate imposed by section 3111 (b)".

(d) (1) Section 6413 (c) (1) (D) of such Code is amended by inserting "(i)" immediately after "(H)", by striking out "section 3101" and inserting "section 3101 (a)" in lieu thereof, and by inserting immediately before the period at the end thereof: "; and (ii) during any calendar year beginning on or after the effective date of health security taxes (as defined in section 3121 (u)) the wages received by him during such year exceed the health security contribution base (as defined in section 3121 (t)) for that year, the employee shall be entitled (subject to the provision of section 31 (b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101 (b) and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to an amount of such wages received in such calendar year equal to the health security contribution base for such year".

(2) Section 6413 (c) (2) (A) of such Code is amended by striking out "includes for the purposes of this subsection the amount" and inserting in lieu thereof "includes for the purposes of this subsection (i) with respect to the taxes imposed by section 3101 (a), the amount"; and by striking out "determined by each such head" and inserting in lieu thereof "and (ii) with respect to the taxes imposed by section 3101 (b), the amount for any calendar year equal to the health security contribution base (as defined in section 3121

(7)) for such calendar year; each such amount to be determined by each such head".

(e) Section 218 of the Social Security Act (relating to agreements for the coverage of services performed in the employ of States and their political subdivisions and instrumentalities) is amended—

(1) (A) by striking out, in subsection (e) (1) (A), "sections 3101 and 3111" and "section 3121" and inserting in lieu thereof, "sections 3101 (a) and 3111 (a)" and "section 3121 (b)", respectively;

(B) by striking out, in subsection (e) (2) (B), "section 3111" and inserting in lieu thereof, "section 3111 (a)"; and

(C) by adding at the end of subsection (e) the following paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section, no State shall be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed on or after the effective date of health security taxes (as defined in section 3121 (u) of the Internal Revenue Code of 1954), amounts equivalent to the taxes which would be imposed by sections 3101 (b) and 3111 (b) of such Code if such service constituted employment as defined in section 3121 (b) or section 3121 (s) of such Code."; and

(2) by striking out in subsection (h) (1), "and the Federal Hospital Insurance Trust Fund", and striking out in such subsection "subsection (a) (3) of section 201, subsection (b) (1) of such section, and subsection (a) (1) of section 1817, respectively" and inserting in lieu thereof "subsections (a) (3) and (b) (1) of section 201."

EXCLUSION FROM GROSS INCOME

SEC. 203. (a) Section 106 of the Internal Revenue Code of 1954 (excluding from gross income employer contributions to accident and health plans for their employees) is amended by inserting immediately before the period at the end thereof: ", and payments by the employer (without deduction from the remuneration of the employees) of the tax imposed upon his employees by section 3101 (b)".

(b) The heading of section 106, and the line referring to that section in the table of contents in subtitle A, chapter 1, subchapter B, part III of such Code, are each amended by adding at the end: "and employer payment of health security taxes".

EFFECTIVE DATES OF PART A

SEC. 204. The amendments made by section 201 of this Act, and the amendments made by subsections (b) and

(d) of section 202, shall be effective only with respect to remuneration received, and remuneration paid, on or after the effective date of health security taxes (as defined by section 3121 (u) of the Internal Revenue Code of 1954, added by section 201 (c) of this Act), and section 3121 (s) of such Code shall be applicable only with respect to remuneration for services performed on or after that date. The amendments made by subsections (a), (c), and (e) of section 202 shall be effective only with respect to remuneration for services performed on or after such effective date. The amendments made by section 203 shall apply to taxable years beginning on or after such effective date.

PART B—TAXES ON SELF-EMPLOYMENT INCOME AND UNEARNED INCOME

TAX OF SELF-EMPLOYMENT INCOME

SEC. 211. (a) Section 1401 (b) of the Internal Revenue Code of 1954 (imposing a hospital insurance tax on self-employed individuals) is amended to read as follows:

"(b) HEALTH SECURITY.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.5 percent of the self-employment income for such taxable year."

(b) Section 1402 (b) of such Code (defining self-employment income) is amended—

(1) by striking out "except that such term shall not include—" and inserting in lieu thereof "except that—," and by amending so much of clause (1) as precedes subclause (A) to read as follows:

"(1) for the purpose of section 1401 (a), such term shall not include that part of the net earnings from self-employment which is in excess of—";

(2) by inserting, immediately after the word "wages" in each of the subclauses of clause (1), "(as defined in section 3121 (b))";

(3) by striking out "or" at the end of clause (1) and inserting "and" in lieu thereof, and by striking out clause (2) and inserting in lieu thereof the following:

"(2) for the purposes of section 1401 (b), such term shall not include that part of the net earnings from self-employment which is in excess of (A) an amount equal to the health security contribution base (as defined in section 3121 (t)) for the calendar year in which the taxable year begins, minus (B) the amount of wages (as defined by section 3121 (r) for the purposes of section 3101 (b)) paid to such individual during the taxable year; and

"(3) for the purposes of both section 1401 (a) and section 1401 (b), such term shall not include any net earnings from self-employment if such net earnings for the taxable year are less than $400."; and

(4) by striking out "(A)" in the sentence following clause (3), and by changing the comma following the term "section 3121 (b)" in that sentence to a period and striking out the remainder of the sentence.

(c) Section 1402 (d) of the Code is amended by striking out "and the term 'wages'", and striking out "**and wages**" in the subsection heading.

TAX ON HEALTH SECURITY UNEARNED INCOME

SEC. 212. Section 1403 of the Internal Revenue Code of 1954 is redesignated as section 1404, and the following new section is inserted immediately after section 1402:

"SEC. 1403. TAX ON HEALTH SECURITY UNEARNED INCOME.

"(a) IMPOSITION OF TAX.—In addition to other taxes, there shall be imposed for each taxable year beginning on or after the effective date of health security taxes (as defined in section 3121 (u)), on the income of every individual residing in the United States whose health security unearned income (as defined in subsection (b) of this section) for the taxable year is $400 or more, a tax equal to 2.5 percent of the amount of such health security unearned income for such taxable year.

"(b) Definition of Health Security Unearned Income.—The term 'health security unearned income' means an amount determined by deducting from the adjusted gross income of an individual for the taxable year any part of such income (whether from wages or any other source) in excess of the amount of the health security contribution base (as defined in section 3121(t)) for the calendar year in which such taxable year begins, and deducting from the remainder any part of the adjusted gross income which—

"(1) consists of wages taxable under section 3101(b), or

"(2) consists of self-employment income taxable under section 1401 (b), or

"(3) consists of remuneration for services performed in the employ of the United States as President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress, or as a member of a uniformed service on active duty, or

"(4) consists of remuneration (not taxable under section 3101(b)) for service performed by an alien in the employ of a foreign government, an instrumentality of a foreign government, or an international organization, or

"(5) consists of payments excluded from wages taxable under section 3101(b) by reason of paragraphs (2) through (13) of section 3121(a) as incorporated in section 3121 (r), or

"(6) in the case of a taxpayer who has attained the age of 60 years before or during the taxable year, consists of any other income in an amount not exceeding $5,000."

CONFORMING AND TECHNICAL AMENDMENTS

SEC. 213. (a) The heading and table of contents of chapter 2 of subtitle A of the Internal Revenue Code of 1954 are amended to read as follows:

"CHAPTER 2—TAXES ON SELF-EMPLOYMENT INCOME AND HEALTH SECURITY UNEARNED INCOME

"Sec. 1401. Rates of tax on self-employment income.
"Sec. 1402. Definitions relating to self-employment income.
"Sec. 1403. Tax on health security unearned income.
"Sec. 1404. Miscellaneous provisions."

(b) Section 1401 of the Code, as amended by section 211(a) of this Act, is further amended by striking out the heading of the section and inserting in lieu thereof:

"SEC. 1401. RATES OF TAX ON SELF-EMPLOYMENT INCOME"

(c) Section 1404 of the Code (as redesignated by section 212 of this Act) is amended by striking out "Self-Employment Contributions Act of 1954" and inserting in lieu thereof, "Self-Employment and Health Security Contributions Act."

(d) Section 6015 of the Code (relating to declarations of estimated income by individuals) is amended by striking out in subsection (c) (2) "the amount of the self-employment tax imposed by chapter 2" and inserting in lieu thereof "the amount of the taxes imposed by chapter 2".

(e) Section 6017 of the Code is amended—

(1) by striking out the heading of the section and inserting in lieu thereof,

"SEC. 6107. SELF-EMPLOYMENT AND HEALTH SECURITY TAX RETURNS.";

(2) by inserting, immediately after the first sentence of the section, the following sentence: "Every individual residing in the United States and having health security unearned income of $400 or more for the taxable year shall make a return with respect to the health security unearned income tax imposed by chapter 2."; and

(3) by striking out "the tax" in the sentence immediately following the insertion made by paragraph (2) and inserting in lieu thereof "the taxes", and by inserting immediately before the period at the end of that sentence, "or on the separate health security unearned income of each spouse, as the case may be".

EFFECTIVE DATES OF PART B

SEC. 214. The amendments made by sections 211, 212, and section 213 (d) and (e) (other than section 213 (e) (1)) shall be effective with respect to taxable years beginning on or after the effective date of health security taxes (as defined by section 312 (u) of the Internal Revenue Code of 1954, added by section 201 (c) of this Act). The amendments made by section 213 (a), (b), (c), and (e) (1) shall be effective on such effective date.

PART C—INCOME TAX DEDUCTIONS FOR MEDICAL CARE

DENIAL OF DEDUCTIONS FOR SERVICES COVERED BY HEALTH SECURITY ACT

SEC. 221. (a) Section 213 of the Internal Revenue Code of 1954 (relating to income tax deductions by individuals for the cost of medical care) is amended—

(1) by inserting, immediately after the words "for medical care" in paragraph (1) of subsection (a), "(other than any amount paid for medical care covered by the Health Security Act)";

(2) by striking out, in subsection (e) (1) (C), "(including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged)"; and

(3) by adding at the end of subsection (e) the following paragraph:

"(5) The term 'medical care covered by the Health Security Act' means health services for which the individual receiving medical care was entitled to have payment made under title I of the Health Security Act (or for which he would have been entitled to have payment made upon obtaining the services from a participating provider of services under such Act), including the costs of insurance against expenses incurred for any such services."

(b) Section 162 of such Code (relating to income tax deduction for trade or business expenses) is amended by redesignating subsection (f) as subsection (g), and inserting immediately after subsection (e) the following subsection:

"(f) No deduction shall be allowed for the cost of medical care covered by the Health Security Act (as defined in section 213 (e) (5))."

(c) The amendments made by subsections (a) and (b) shall be applied with respect to medical care received on or after the effective date of health security benefits, as set forth in section 163 of the Health Security Act.

TITLE III—COMMISSION ON THE QUALITY OF HEALTH CARE

STATEMENT OF PURPOSE

SEC. 301. It is the purpose of this title to improve the quality of health care in the United States by establishing a Commission on the Quality of Health Care to develop parameters and standards for care of high quality, and to promote the application of such parameters and standards in assessing and enhancing the quality of care furnished under the Health Security Act.

AMENDMENT OF THE PUBLIC HEALTH SERVICE ACT

SEC. 302. The Public Health Service Act is amended by inserting after title XVI the following new title:

"TITLE XVII—COMMISSION ON THE QUALITY OF HEALTH CARE

"ESTABLISHMENT OF THE COMMISSION

"SEC. 1701. (a) There is hereby established in the Department of Health, Education, and Welfare a Commission on the Quality of Health Care (hereinafter in this title referred to as the 'Commission'), consisting of eleven members to be appointed by the Secretary after consultation with the Health Security Board, which shall perform the functions set forth in sections 1702 and 1703.

"(b) The Commission shall consist of persons who are especially qualified by education and experience to perform the functions of the Commission, including seven persons who are representatives of providers of health services or representatives of nongovernmental organizations engaged in developing standards pertaining to the quality of health care, and four persons who are representatives of consumers of health care (who shall be persons not engaged in, and having no financial interest in, the furnishing of health services). Each member shall hold office for a term of five years, except that (1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term and (2) the terms of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the appointment and qualification of at least six members of the Commission. A majority of the members who have been appointed and qualified shall constitute a quorum for the transaction of business.

"(c) The Secretary shall designate one of the members of the Commission to serve, at the will of the Secretary, as Chairman of the Commission.

"(d) Subject to general policies established by the Secretary, and to the availability of funds, the Commission is authorized to employ such personnel as it finds necessary, including experts and consultants employed in accordance with section 3109 of title 5, United States Code, and to appoint one or more advisory committees (including a committee on the preparation and analysis of statistics) which may include officers or employees of the United States or of State or local governments. Members of committees who are not otherwise in the full-time employ of the United States, and experts and consultants employed pursuant to this subsection, while serving on business of the Commission (inclusive of traveltime), shall receive compensation at rates fixed by the Commission, but not in excess of the daily rate paid under GS–18 of the General Schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"FUNCTIONS OF THE COMMISSION

"SEC. 1702. (a) The primary responsibility of the Commission shall be the initiation and continuing development of methods of assessing the quality of health care furnished under the Health Security Act and methods of utilizing such assessments for the maintenance and improvement of quality, and the submission to the Secretary and the Health Security Board of its findings and recommendations. In discharging this responsibility the Commission shall—

"(1) undertake the systematization and nationwide collection of data bearing on (A) the qualifications of health personnel and the adequacy of health facilities to furnish care of high quality, (B) the patterns of medical and other health practice in actual episodes of care, (C) the patterns of utilization of the components of the health care system, and (D) the health of patients during and at the conclusion of episodes of health care, and the relation of the foregoing elements of health care thereto;

"(2) develop from such date (on a national or regional basis, for particular population groups, or otherwise, as the Commission may deem most useful) statistical norms and ranges with respect to aspects of health care which are comprised by each of the four elements listed in paragraph (1);

"(3) develop, on the basis of these norms and ranges, such standards (together with acceptable deviations therefrom) as will afford useful gages of the quality of care and useful instruments for the control and improvement of quality; and

"(4) make recommendations to the Secretary and the Health Security Board for the use of standards developed under paragraph (3) in the exercise by the Board of its authority under title I, part H, of the Health Security Act, or for their use in the development of recommendations to the Congress for amendment of the Health Security Act. In carrying out its duties under this subsection, the Commission shall emphasize, and give first consideration to,

care furnished for those illnesses and conditions which have relatively high incidence in the population and which are relatively amendable to medical or other care.

"(b) The Commission shall, through its staff or by contract (or both), conduct a program of research with the objectives of—

"(1) improving the technology of assessing the quality of health care, with regard for both the service input and the end result of such care;

"(2) comparing the quality of health care furnished under different systems of delivery and methods of payment;

"(3) analyzing the effects of consumer health education, and of utilization of preventive health services;

"(4) continuing the studies made by the Secretary's Commission on Medical Malpractice, and appraising the effect of measures taken by the Health Security Board pursuant to section 146 of the Health Security Act; and

"(5) obaining other information which the Commission believes will be useful in effectuating the purpose of this title and of title I, part H, of the Health Security Act.

"(c) The Commission is authorized to provide technical assistance to participating providers of health services under title I of the Health Security Act (1) in furnishing to the Health Security Board information required for purposes of the Commission, and (2) in developing and carrying out programs of quality control.

"ADVICE TO HEALTH SECURITY BOARD PENDING DEVELOPMENT OF STANDARDS

"SEC. 1703. Pending the development of standards and recommendations pursuant to section 1702(a), the Commission shall, both before and after the effective date of health benefits under title I of the Health Security Act, on the basis of such knowledge as is available from time to time, furnish advice and recommendations to the Health Security Board on the issuance of regulations under part H of such title.

"SEC. 1704. The Secretary is authorized to establish on the staff of the Commission, and to fix compensation for, not more than twenty-five positions in the professional, scientific, and executive service, each such position being established to effectuate those research and development activities of the Commission which require the services of specially qualified scientific, professional, and administrative personnel. The rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than the minimum rate of grade 16 of the General Schedule of the Classification Act of 1949, as amended, nor more than the highest rate of grade 18 of the General Schedule of such Act; and the rates of compensation for all such positions shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may designate for this purpose."

TITLE IV—REPEAL OR AMENDMENT OF OTHER ACTS

REPEAL OF MEDICARE AND FEDERAL EMPLOYEE HEALTH BENEFIT STATUTES

SEC. 401. (a) Effective on the effective date of health security benefits (set forth in section 163)—

(1) Title XVIII of the Social Security Act, except section 1817 thereof, is repealed.

(2) The Act of September 28, 1959 (5 U.S.C., chap. 89), and Public Law 86–724 are repealed.

(b) Subsection (a) shall not affect any right or obligation arising out of any matter occurring before the effective date of health security benefits or any administrative or judicial proceeding (whether or not initiated before that date) for the adjudication or enforcement of any such right or obligation.

MEDICAID STATUTE

Sec. 402. After the effective date of health security benefits no State (as defined in section 1101 (a) (1) of the Social Security Act) shall be required, as a condition of approval of its State plan under title XIX of that Act, to furnish any service which constitutes a covered service under title I of this Act, and any amount expended for the furnishing of any such service to a person eligible for services under title I of this Act shall be disregarded in determining the amount of any payment to a State under such title XIX. The Secretary of Health, Education, and Welfare shall by regulation prescribe the minimum scope of services required (in lieu of the requirements of section 1902 (a) (13) of the Social Security Act) as a condition of approval, after the effective date of health security benefits, of a State plan under such title XIX. Such minimum scope of services shall, to the extent the Secretary finds practicable, supplement the benefits available under title I of this Act, including supplementation with respect to the duration of skilled nursing home services during the benefit period and with respect to the furnishing of dental services and of drugs (appearing on the list established under section 25(b) of this Act) to persons not entitled to such services, or not entitled to such drugs, under title I of this Act.

VOCATIONAL REHABILITATION ACT; MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SEC. 403. Funds made available under the Vocational Rehabilitation Act or under title V of the Social Security Act shall not be used, after the effective date of health security benefits, to pay for personal health services available under title I of this Act, but they may, in accordance with regulations of the Secretary of Health, Education, and Welfare, be used (a) to pay for institutional services which are either more extensive or more intensive than the services recognized in institutional budgets approved under title I of this Act, or (b) to pay for special medical or other procedures peculiar to vocational rehabilitation, or peculiar to the correction or amelioration of defects or chronic conditions of crippled children, as the case may be.

AMENDMENT OF SECTION 1122 OF THE SOCIAL SECURITY ACT

SEC. 404. (a) Section 1122 of the Social Security Act is amended—

(1) by striking out the words "titles V, XVIII, and XIX" whenever they appear in the section and inserting in lieu thereof "titles V and XIX of this Act and title I of the Health Security Act", and striking out "title V, XVIII or XIX" in subsection (d) (2) and inserting in lieu thereof "title V or XIX of this Act or title I of the Health Security Act";

(2) by striking out the words "in determining the Federal payments" wherever they appear in subsections (d) (1) and (e) and inserting in lieu thereof "for the purpose of determining the Federal payments";

(3) by striking out in subsection (d) (1) "not include any amount" and "exclude an amount" and inserting in lieu thereof, respectively, "not include, and shall direct the Health Security Board not to include, any amount" and "exclude, and shall direct the Health Security Board to exclude, an amount";

(4) by striking out in subsection (i) (2) "the Health Insurance Benefits Advisory Council" and insert in lieu thereof "the National Health Security Advisory Council".

(b) The amendments made by subsection (a) shall be effective upon the effective date of health security benefits except that prior to that date the Secretary of Health, Education, and Welfare may issue to the Health Security Board directions for reductions in payments to be made on and after the effective date.

REPEAL OF TITLE XI, PART B, OF THE SOCIAL SECURITY ACT

SEC. 405. Part B of title XI of the Social Security Act (relating to Professional Standards Review), and section 249F of the Social Security Amendments of 1972 (which added that part to the Act) are repealed, effective on the effective date of health security benefits.

TRANSFER AND AMENDMENT OF SECTION 1817, AND AMENDMENT OF SECTION 201 (g), OF THE SOCIAL SECURITY ACT

SEC. 406. (a) Section 1817 of the Social Security Act (creating the Federal Hospital Insurance Trust Fund and appropriating to the fund the proceeds of the hospital insurance payroll taxes and the hospital insurance self-employment tax) is redesignated as section 61 and is transferred to this Act, to appear under the heading "HEALTH SECURITY TRUST FUND" as the first section of part D of title I; and is amended—

(1) by striking out the section heading, and by striking out the name of the trust fund appearing in sub-

section (a) and inserting in lieu thereof, "Health Security Trust Fund";

(2) by striking out paragraph (2) of subsection (a) (appropriating to the Trust Fund the proceeds of the self-employment tax for hospital insurance) and inserting in lieu thereof:

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income, and by section 1403 of the Code with respect to unearned income, reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code."

(3) by striking out subsections (g) and (h), and inserting in lieu thereof:

"(g) On the effective date of health benefits, there shall be transferred to the Trust Fund all of the assets and liabilities of the Federal Supplementary Medical Insurance Trust Fund. The Health Security Trust Fund shall remain subject to the liabilities of the Federal Hospital Insurance Trust Fund existing immediately prior to such effective date.

"(h) In addition to the sums appropriated by subsection (a), there are authorized to be appropriated to the Trust Fund from time to time, out of any moneys in the Treasury not otherwise appropriated, a governmental contribution equal to 100 per centum of the sums appropriated by subsection (a). There shall be deposited in the Trust Fund all recoveries of overpayments, and all receipts under loans or other agreements entered into, under this title.

"(i) The managing trustee shall pay from time to time from the Trust Fund such amounts as the Board certifies are necessary to make payments provided for by this title, and the payments with respect to administrative expenses in accordance with section 201 (g) of the Social Security Act."

(b) Section 201 (g) of the Social Security Act (providing for annual authorization by the Congress of payment, from the respective trust funds, of the cost of administering the several national systems of social insurance) is amended—

(1) by striking out in paragraph (1) (A) "the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund" and inserting in lieu thereof: "the Health Security Trust Fund";

(2) by striking out the words "title XVIII" wherever they appear in the subsection and inserting in lieu thereof: "title I of the Health Security Act"; and

(3) by striking out the words "for which the Secretary of Health, Education, and Welfare is responsible" wherever they appear in paragraph (1) (A), and inserting in lieu thereof, "for which the Secretary of

Health, Education, and Welfare and the Health Security Board are responsible".

(c) All references to the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund, appearing in any Act other than this Act or the Social Security Act, shall be deemed to refer to the Health Security Trust Fund.

(d) For the effective date of subsections (a) and (b), see section 163. Subsection (c) shall be effective on and after the effective date of health benefits.

AMENDMENTS OF TITLE XV OF THE PUBLIC HEALTH SERVICE ACT

SEC. 407. (a) Section 1501(a) of the Public Health Service Act is amended by striking out "within eighteen months" and inserting in lieu thereof "within twelve months".

(b) Section 1501(b) of such Act is amended by adding after paragraph (2) thereof the following sentence: "Such guidelines shall emphasize the need for prompt action to enable providers of health services better to meet the demands upon them when benefits under title I of the Health Security Act become available.".

(c) Section 1503(b) of such Act is amended by striking out "and the Assistant Secretary for Health of the Department of Health, Education, and Welfare" and inserting in lieu thereof, "the Under Secretary for Health and Science of the Department of Health, Education, and Welfare, and the Chairman of the Health Security Board".

(d) Section 1513(d) of such Act is amended by striking out paragraph (1) thereof and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(e)(1) Section 1513(e)(1) of such Act is amended by inserting, immediately after "1970", a comma and the following: "or made available under part F of title I of the Health Security Act,".

(2) Section 1513(e)(2) of such Act is amended by striking out "the Secretary" in the first and second sentences thereof, and inserting in lieu thereof in each instance "the Secretary or the Health Security Board"; by striking out "he" in the second sentence and inserting "the Secretary" in lieu thereof; and by inserting after "may make" in the fourth sentence "(or authorize the Health Security Board to make)".

(f) Section 1526 of such Act is repealed.

SALARY LEVELS

SEC. 408. (a) Section 5313, title 5, United States Code (relating to executive pay rates for positions at level II) is amended by adding at the end thereof the following new clause:

"(23) Deputy Secretary of Health, Education, and Welfare."

(b) Section 5314, title 5, United States Code (relating to executive pay rates for positions at level III) is amended by striking out clause (7) and inserting in lieu thereof:

"(7) Under Secretary for Health and Science, Department of Health, Education, and Welfare.";

and by adding at the end thereof the following new clause:

"(61) Chairman, Health Security Board, Department of Health, Education, and Welfare."

(c) Section 5315, title 5, United States Code (relating to executive pay rates for positions at level IV), is amended by adding at the end thereof the following new clauses:

"(105) Members (other than the Chairman), Health Security Board, Department of Health, Education, and Welfare (4)."

"(106) Members, Commission on the Quality of Health Care, Department of Health, Education, and Welfare (11)."

(d) Section 5316, title 5, United States Code (relating to executive pay rates for positions at level V) is amended by adding at the end thereof the following new clause:

"(137) Executive Director, Health Security Board, Department of Health, Education, and Welfare."

AMENDMENT OF BUDGET AND ACCOUNTING ACT

SEC. 409. (a) Section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), is amended—

(1) by striking out "The Budget" in the second sentence of subsection (a) and inserting in lieu thereof "Except as provided in subsection (d), the Budget"; and

(2) by adding at the end thereof the following new subsection:

"(d) The Budget shall set forth the items referred to in paragraphs (4), (5), (6), (7), (8), (9), and (12) of subsection (a) which are attributable to receipts of and expenditures from the Health Security Trust Fund, and shall set forth separately such items (commonly referred to as the 'administrative budget') attributable to all other operations of the Government."

(b) The amendments made by subsection (a) shall be effective with respect to the fiscal year beginning in the first calendar year after the calendar year in which this Act is enacted, and to all subsequent fiscal years.

TITLE V—STUDIES RELATED TO HEALTH SECURITY

STUDY OF THE PROVISION OF HEALTH SECURITY BENEFITS TO UNITED STATES CITIZENS IN OTHER COUNTRIES

SEC. 501. The Secretary of Health, Education, and Welfare, in consultation with the Secretary of State and the Secretary of the Treasury, shall study (a) the practicability and the means of making prepaid health services (or prepaid indemnification for the cost of health services) available, more widely than can be done under section 12 of this Act, to citizens of the United States who are resident in other countries or are temporarily visiting such countries, by supplementing the authority for reciprocal arrangements under section 12 with authority for payments from the Health Security Trust Fund, and (b) means of equitably financing such services (or indemnification) through the extension of health security taxes; and not later than five years after the enactment of this Act shall report to the Congress his findings and recommendations.

STUDY OF COORDINATION WITH OTHER FEDERAL HEALTH BENEFIT PROGRAMS

SEC. 502. (a) The Secretary of Health, Education, and Welfare shall conduct studies of the most satisfactory means of coordinating the program for the health care of merchant seamen, the program for the health care of Indians and Alaskan Natives, or both, with the system of health security benefits created by this Act; the Administrator of Veterans' Affairs and the Secretary shall conduct a joint study of the most satisfactory means of coordinating with that system some or all of the programs for the health care of veterans; and the Secretary of Defense and the Secretary of Health, Education, and Welfare shall conduct a like joint study with respect to the program of health benefits furnished by civilian facilities and personnel to dependents of members of the Armed Forces. Reports of these studies, and legislative recommendations to achieve improved coordination, shall be submitted to the Congress not later than three years after the enactment of this Act.

(b) In conducting the studies required by this section, the Secretaries and the Administrator, as appropriate, shall consult with representatives of the respective beneficiary groups, and shall include in their reports to the Congress summaries of the views of such representatives.

GENERAL PROVISIONS

SEC. 503. (a) There are hereby authorized to be appropriated such sums as may be necessary for the conduct of the studies authorized by this title.

(b) In conducting such studies the Secretary of Health, Education, and Welfare, the Secretary of Defense, and the

Administrator of Veterans' Affairs are each authorized (1) to appoint such experts and consultants (employed in accordance with section 3109 of title 5, United States Code) and such advisory committees as they may deem necessary; and (2) to enter into contracts with public or private agencies or organizations for the collection of information, the conduct of research, or other purposes related to the respective studies. Experts and consultants and members of advisory committees appointed under this subsection, while serving on business related to the studies (inclusive of travel-time), shall receive compensation at rates not in excess of the daily rate paid under GS–18 of the General Schedule under Section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

94TH CONGRESS
1ST SESSION

H. R. 3252

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 19, 1975

Mr. KETCHUM (for himself and Mr. LAGOMARSINO) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

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A BILL

To provide for the establishment of a National Voluntary Medical and Hospital Services Insurance Act

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act be cited as the "National Voluntary Medical and Hospital Services Insurance Act of 1975".

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress hereby finds that illness and accident are unpredictable hazards to all persons and that the financial cost of needed hospital and medical treatment may become a hardship upon any person or prevent their access to or receipt of needed hospital and medical treatment, a national agency shall be established to operate a medical and hospital services insurance plan, with funds supplied by voluntary subscriptions from subscribers, and matching United States Treasury general funds, to pay all reasonable costs of all medically necessary, available, and appropriate medical and hospital services for all voluntary enrollees.

(b) The Congress also finds that the United States has no precedent or experience with universal health insurance but takes note of the experience of the twenty-two million residents of Canada in evolving from conditions and methods of public- and private-health care financing closely resembling existing conditions and methods in the United States to an effective and economical system of ten different compulsory and voluntary Provincial health insurance plans assisted financially by the Government of Canada; from which can be drawn the following valuable lessons and general principles to guide us in planning to best meet our own particular needs:

(1) In practice, the actual utilization of insurance benefits by a whole population is primarily determined by the health care providers rather than by capricious demands of patients and, therefore, all artificial regulatory mechanisms such as user copayments, deductibles, and limits are not only unnecessary, but, on the contrary, tend to be self-defeating and counterproductive by greatly increasing

administrative costs and overburdening doctors and hospitals with paperwork and also by deterring many persons from seeking early diagnosis of disease and treatment which could be both most effective and most economical.

(2) The medical profession itself is best qualified to regulate the utilization and costs of insurance benefits and can be relied on with confidence to perform this responsibility faithfully and effectively in the best interests of the health of the American people, without the necessity for a pervasive and costly administrative and supervisory system, user copayments, deductibles, or limits.

(3) Compulsory direct taxation or subscription by individuals or employers to any national health insurance plan is undesirable because it grants an implied right to every subscriber to expect to receive health care service wherever and whenever demanded, and such expectations are clearly infeasible, unrealizable, and prohibitively costly, and would impose excessive demands on available medical manpower and facilities, inevitably necessitating government intervention in medical practice and allocation of services; whereas universally affortable voluntary subscription may be predicated on the clear understanding and acceptance by all subscribers that the insurance benefits are intended only to pay for whatever services are medically necessary and readily available in the free marketplace.

(4) Total administrative costs would be substantially lower and the benefits of the insurance would be more equitable and uniform under one national health insurance plan operated by a single-purpose agency of the United States, than under a multitude of separate programs administered by the various States or a multi-purpose agency.

SEC. 3. (a) The National Voluntary Medical and Hospital Services Insurance Act of 1975 shall create a National Voluntary Medical and Hospital Services Insurance Agency to operate a National Voluntary Medical and Hospital Services Insurance Plan and which shall have a Director nominated by the President of the United States to be confirmed by the Senate of the United States and to serve thereafter at the discretion of the President and who shall appoint six assistant directors, of whom not less than three shall be medical doctors, who together shall appoint or assemble such deputy directors, staff, consultants, contractors, quarters, and facilities as the Directors shall deem necessary to carry out the responsibilities and functions of the agency, including the preparation of an annual budget and an annual operations report and financial statement and accounting of all receipts and expenditures, audited and certified by the General Accounting Office, for the President and the Congress.

(b) The Agency shall have two operational subdivisions: one subdivision shall exclusively conduct all relations with hospital service providers and the payment of hospital service benefits of the Plan; one subdivision shall exclusively conduct all relations with medical and pathological laboratory service providers and the payment of medical and pathological laboratory benefits of the plan and such additional benefits as may be provided by the Plan in the future.

DEFINITIONS

SEC. 4. For purposes of this Act—

(1) "Agency" shall herein mean and refer to the National Voluntary Medical and Hospital Services Insurance Agency created by this Act;

(2) "Plan" shall herein mean and refer to the National Voluntary Medical and Hospital Services Insurance Plan operated by the Agency;

(3) "subscriber" shall herein mean and refer to any adult person, eighteen years of age or older, who has enrolled himself or herself and his or her spouse and dependent children and adult or child wards, if any, in the Plan and has paid the requisite premium for each enrollee; or an employer or a public agency that enrolls, and remits premiums to the Plan on behalf of one or more employees or clients;

(4) "enrollee" shall herein mean and refer to any person enrolled in the Plan by a subscriber and whose

requisite premium has been paid and is in force, and who has been assigned a Plan account number, which shall also identify the enrollee's subscriber;

(5) "family" shall herein mean and refer to any adult person eighteen years of age or older and spouse and all dependent children, adults, or wards, if any, whether residing together in the same household or not;

(6) "adult" shall herein mean and refer to any person eighteen years of age or older;

(7) "child" shall herein mean and refer to any person under the age of eighteen years;

(8) "provider" shall herein mean and refer to any person, partnership, association, or corporation that provides and claims payment for any medical, pathological laboratory or hospital service that is a benefit of the Plan;

(9) "doctor" shall herein mean and refer to any person who is licensed by their State professional licensure agency as a Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Podiatric Medicine, or Doctor of Dental Surgery, who personally provides, performs, prescribes, orders, supervises, or certifies any medical service classified as a benefit of the Plan, whether or not he or she has assigned any or all related fees to an employer, partnership, association, or corporation;

(10) "hospital" shall herein mean and refer to any establishment, with or without sleeping or feeding facilities, which provides patient diagnostic, therapeutic, or maintenance services or materials or staff for use only by or under the direction, supervision, and certification of a doctor, and for which a separate charge is made to the patient and which has been duly licensed and certified by all jurisdictional public health and safety agencies and which has been approved by the Agency for participation in the Plan;

(11) "laboratory" shall herein mean and refer to any separate establishment inside or outside of a hospital, a clinic, or a doctor's regular office and which is supervised at all times by a licensed medical doctor who is qualified as a specialist in pathology and which performs diagnostic pathological tests at the request only of doctors on behalf of patients who are charged separate fees for such services by the laboratory, and which has been duly licensed and certified by all jurisdictional public health, safety, and business regulatory agencies and which has been approved by the Agency for participation in the Plan or the provision of specified pathological tests.

INITIATION AND INCEPTION OF THE PLAN

SEC. 5. (a) When this Act becomes operative through the signature of the President and the appointment of a Director, the Agency shall be charged with responsibility to forthwith make all necessary preparations to offer subscriptions and enrollments, and to commence payment of claims for benefits of the Plan everywhere in the United States and its territories within a period of two years or less such preparations to include the employment of staff; the occupation of quarters; the printing and distribution of informational and operational material for and respecting subscription, enrollment, premiums, benefits, claim forms, auditing and processing and payment of claims; establishment of medical and laboratory service fee and hospital rate and charge schedules; establishment of utilization review and control procedures; establishment of sanctions and disciplinary procedures for illegal or unwarranted utilization of benefits; and the preparation of a budget and projection of operations to guide the Congress in the appropriation of United States Treasury general funds to supplement subscribers' premiums in operating the Plan for the succeeding calendar year.

(b) The Congress shall appropriate sufficient interim funds from the United States Treasury general funds to enable the Agency to carry out the responsibilities and functions specified in section 5(a), within the time specified, and to this end shall appropriate to the Agency the sum of $50,000,000 for the first calendar year after this Act becomes operative.

(c) Not less than ninety days prior to the effective date of inception of the Plan, all persons who are enrolled in or subscribers to or beneficiaries of the medicare program administered by the Social Security Administration and the CHAMPUS program administered by the Department of Defense, and all States participating in the medicaid program and their resident beneficiaries of assistance provided by that program, shall be notified that all medical and hospital service benefits provided by or through those programs will cease on the effective date of inception of the Plan; and such notice shall be accompanied by an explanation of the Plan provided by this Act and an application form for enrollment in and subscription to the Plan to effectuate eligibility for the medical and hospital benefits of the Plan on the effective date of inception of the Plan.

DUPLICATION OF SERVICES AND FUNCTIONS PROVIDED BY OTHER AGENCIES

SEC. 6. (a) On the effective date of inception of the Plan, when the Agency shall offer subscriptions and enrollments and commence payment of claims for benefits of the Plan, the Congress shall withhold all appropriations for the funding of all similar or duplicate hospital and medical service insurance benefits or payments provided by any other agency of the United States, including but not necessarily limited to those programs generally known as medicare and medicaid under the jurisdiction of the Department of Health, Education, and Welfare and the program generally known as CHAMPUS, administered by the Department of Defense, and every such program operated by any agency of the United States, whether specified or not, shall immediately cease providing or paying for medical or hospital service for members of the general public on a fee or charge for service basis.

(b) If the programs specified in section 6(a) or any other programs operated or administered by any agency of the United States provide any benefit, service or function other than the direct provision of payment for medical and hospital service for members of the general public not enlisted or commissioned in the Armed Forces or Coast Guard, entitled to such benefits from the Department of Veterans Affairs, residing in an Indian reservation or in the custody of a penal or mental institution, such other benefit, service, or function shall not be denied necessary operating funds by Congress insofar as the purpose and intention of this Act are concerned.

BENEFITS OF THE PLAN

Sec. 7. (a) Medical Service.—Payment shall be made by the Plan to or on behalf of every enrollee for all legal, appropriate, professionally recognized and medically necessary medical service provided as a personal professional service by or under direct supervision of a licensed medical doctor, wherever performed, including but not necessarily limited to noncutting physical and psychiatric medicine, surgery, obstetrics, radiological and electrical procedures, pathology tests, transfusions, medication and immunization, injections and anesthesia; and for the same kind of services provided by a doctor of osteopathic medicine who is licensed by any jurisdictional State medical licensing authority.

(b) Dental Surgery.—Payment shall be made by the Plan to or on behalf of every enrollee for all appropriate, professionally recognized, and medically necessary reconstructive oral surgery performed by a doctor of dental surgery in a consenting hospital approved by the Agency.

(c) Podiatric Surgery.—Payment shall be made by the Plan to or on behalf of every enrollee for all appropriate, professionally recognized and medically necessary foot surgery performed by a doctor of podiatric medicine in a consenting hospital approved by the Agency.

(d) Laboratory Service.—Payment shall be made by the Plan or behalf of every enrollee for all professionally recognized pathological tests performed at the request of the enrollee's doctor and under the direct supervision of a Medical Doctor qualified as a specialist in pathology, by a laboratory approved by the Agency for participation in the Plan for specified pathological tests.

(e) HOSPITAL SERVICE.—Payment shall be made by the Plan on behalf of every enrollee for all legal, appropriate, professionally recognized and medically necessary inpatient or outpatient hospital service, supplies, medication, transfusions and food provided by a hospital approved for participation in the Plan by the Agency, including general or special category hospitals, outpatient clinics, emergency wards, convalescent hospitals, nursing homes and acute alcohol or drug toxification treatment centers, when the enrollee is admitted or attended by a licensed doctor on the staff of the hospital.

SERVICES EXCLUDED FROM BENEFITS OF THE PLAN

SEC. 8. No payment shall be made by the Plan on account of:

(1) Any medical advice given to an enrollee by telephone.

(2) Any cosmetic plastic surgery not deemed essential to the physical and mental health of the enrollee and not approved in advance by the Agency.

(3) Any service or supplies or food provided by a hospital at the request of the enrollee and which are not medi-

cally necessary or prescribed by a doctor, such as but not necessarily limited to private or semiprivate accommodation, telephone, private nursing, and food, not ordinarily served or provided to all patients within the hospital's basic per diem rate.

(4) Any medico-legal advice in connection with any legal claim or suit other than as provided in sections 35 (e) and 35 (g).

(5) Any service requested by or for the benefit of a second party other than the enrollee, such as but not necessarily limited to a life insurance application, a past, present, or prospective employer, or any other party with any legal or monetary interest in the health of the enrollee.

(6) Any service that is the responsibility of an enrollee's past or present employer or custodian, such as but not necessarily limited to a workmen's compensation insurer, the Armed Forces, Coast Guard, Veterans' Administration, penal or mental institutions.

(7) Any service that is a covered benefit of any other public or private health insurance plan or prepaid hospital or medical service plan, group or organization, in which the enrollee is enrolled at his own or any other party's expense or is entitled to by any Federal, State, or municipal agency.

(8) Any hospital or laboratory service provided by a hospital or laboratory not approved by the Agency.

(9) Any medical service provided by a doctor who has been excluded from the Plan by unrevoked orders of the Directors of the Agency, except in an emergency when medically necessary service is not available from a nonexcluded doctor.

ASSIGNMENT OF BENEFITS

SEC. 9. It shall be a condition of enrollment in the Plan that every enrollee shall assign to the Agency the full and unreserved right to recover from any third party the full amount of any benefits paid by the Plan on account of medical, laboratory or hospital service provided to the enrollee, and necessitated by the culpable actions or negligence of the third party and which are the liability of the third party.

PREMIUMS AND PREMIUM RECEIPTS

SEC. 10. (a) Premiums shall be paid by every subscriber on account of each enrollee in his or her family or employ, in advance, monthly, quarterly, semiannually, or annually in the amount of $15 per calendar month or $180 per year for each adult and one-half of that amount for each child.

(b) Subscribers who present valid evidence, in a form prescribed by the Agency, showing that their enrollees' total earned and unearned combined family income is less than $9,996 per year ($833 per month, average) shall be entitled to have their annual premiums for each adult enrollee calculated at the rate of 1.8 per centum of total annual earned and unearned combined family income, or one-twelfth of 1.8 per centum of that income monthly, and one-half of that amount for each child enrollee, but in no case shall the adult premium be less than $3 per month or $36 per year and one-half of that amount for each child.

(c) If an enrollee is employed by an employer who remits premiums to the Plan on behalf of employees, it shall be the responsibility of the enrollee to advise the employer of the enrollee's total annual earned and unearned combined family income on which the applicable premium is calculated, as provided in section 10(b).

(d) If two or more enrollees in a family are employed by the same or various employers who remit premiums to the Plan on behalf of employees, it shall be the responsibility of each enrollee to advise their employer of any premiums being remitted to the Plan by every other employer of every other enrollee in the enrollee's family, so that there shall be no duplication in the applicable amount of premiums remitted.

(e) If employment contracts or agreements require one or more employers to pay all or part of Plan premiums and remit such premiums to the Plan on behalf of one or more enrollees in the same family, the excess amount of such premiums payable by the employer shall be paid to the employee as wages and shall not be remitted to the Plan, after notification of the employer as provided in section 10(d).

(f) Every subscriber shall be provided with a receipt for premiums paid for each enrollee of the subscriber, showing the enrollee's name, address, Plan account number, and the calendar period covered by the premium and if the subscriber is the employer of the enrollee the receipt shall show the subscriber's name, address, and Plan account number.

REINSTATEMENT OF COVERAGE

SEC. 11. Enrollment in the Plan shall be reinstated without loss of coverage if any unpaid premiums on account of any enrollees are paid within sixty days of their due date but thereafter coverage shall not be effective and benefits shall not be payable on account of any enrollee for forty-five days after a subscriber has reapplied for enrollment and has paid any premiums then due in advance; and the same shall apply with respect to an enrollee separated from his or her subscriber.

TRUST FUND AND SUBSIDY

SEC. 12. (a) Upon the effective date of inception of the Plan and the offering of subscriptions to the public, the Agency shall establish a trust fund into which shall be deposited all premiums received from subscribers together with an at least equal amount of money appropriated from the United States Treasury general funds; from which shall be paid all claims for the benefits of the Plan and all operating and administrative costs.

(b) During the first three years of operation of the Plan, the Congress may increase the amount of money appropriated from United States Treasury general funds, relative to subscribers' premiums, to be deposited in the trust fund provided in section 12 (a) and accordingly shall appropriate and deposit in the trust fund the amount of $5,000,000,000 on or before the effective date of inception of the Plan.

(c) Section 12 (b) notwithstanding, the amount of United States Treasury general funds appropriated by the Congress and deposited in the trust fund provided in section 12 (a) shall not exceed the amount of subscribers' premiums deposited in the trust fund during the fourth and succeeding years after the effective date of inception of the Plan, except only as provided in section 13 (b).

APPORTIONMENT OF PREMIUMS AND SUBSIDY

SEC. 13. (a) Not less than 35 per centum of all premiums received from subscribers and deposited in the trust fund as provided in section 12 (a) shall be reserved for the payment of medical and laboratory service benefits of the Plan, and not less than 62 per centum of all such premiums shall be reserved for the payment of hospital service benefits of the Plan and not more than 3 per centum of all such premiums shall be used for the payment of operating and administrative costs of the Plan and unrecoverable arbitration costs and awards as provided in section 35 (e) and 35 (g).

(b) Appropriations from United States Treasury general funds in amount at least equal to subscribers' premiums and deposited in the trust fund as provided in section 12 (a) shall be reserved in equal proportion to the amount of premiums reserved for the payment of medical, laboratory, and hospital benefits of the Plan as provided in section 13 (a), and if operating and administrative costs of the Plan and unrecoverable arbitration costs and awards as provided in section 35 (e) and 35 (g), exceed 6 per centum of the amount of subscribers' premiums the Congress shall appropriate and deposit in the trust fund additional United States Treasury general funds in the amount of such excess expenditures.

VOLUNTARY ENROLLMENT AND SUBSCRIPTION

SEC. 14. Enrollment in the Plan and the payment of applicable premiums shall be voluntary and the personal responsibility of every eligible adult resident of the United States and its territories except that nothing in this Act shall be construed as preventing any adult subscriber from enrolling his or her spouse or child or adult dependents in the Plan or any employer from enrolling any employee and the employee's family when the employer pays all or part of the employee's premiums, or any State, county, or municipal welfare agency from enrolling in the Plan any person who is in receipt of public assistance when such public agency pays all or part of the applicable premium for that person.

EFFECTIVE DATE OF BENEFITS AFTER ENROLLMENT

SEC. 15. All benefits of the Plan shall become payable by the Plan on the effective date of inception of the Plan upon enrollment and payment of applicable premiums prior to the date of inception; and thereafter benefits shall become effective and payable forty-five days after the date of enrollment and payment of applicable premiums, except that benefits shall be effective and payable from the date of birth when a parent or guardian has enrolled a child and paid the applicable premium within thirty days after the child's birth.

REIMBURSEMENT OF FEES PAID TO NONPARTICIPATING PROVIDERS

SEC. 16. Every enrollee in the Plan shall be entitled to reimbursement in the lesser amount of either the scheduled fee payable by the Plan to a participating medical service provider for any service that is a benefit of the Plan or the actual fee paid by the enrollee to any qualified nonexcluded and nonparticipating medical service provider within the United States and its territories, upon submission to the Agency of a valid receipted statement for such service and payment.

PARTICIPATION BY MEDICAL SERVICE PROVIDERS

SEC. 17. (a) Every nonexcluded and licensed Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Podiatric Medicine and Doctor of Dental Surgery shall be entitled to be listed by the Plan as a participating provider by making application to the Agency thirty days in advance and shall be supplied by the Agency without charge with an account number, all necessary claim submission forms, schedule of medical services and fees, informational material and two durable display signs at least six by twelve inches in size stating his or her name, professional title, Plan account number, and the following wording: "I am a participating medical service provided in the National Voluntary Medical and Hospital Services Insurance Plan. I will accept your valid Plan premium payment receipt to submit my claim for payment to the Plan. I may require the payment of an extra fee, which will be stipulated before I treat you, and which will be disclosed on my claim to the Plan. You are entitled to know the amount of fee I will be paid by the Plan for treating you.".

(b) Any participating medical service provider may withdraw from the Plan at any time upon giving notice to the Agency in writing thirty days in advance.

(c) Any nonexcluded medical service provider who has voluntarily withdrawn from participation in the Plan shall be entitled to be relisted by the Plan as a participating provider upon giving notice to the Agency in writing thirty days in advance and not less than thirty days after the effective date of prior withdrawal.

(d) Every participating medical service provider shall be required to submit a correctly completed official claim form to the Plan on account of all services that are benefits of the Plan that have been provided to any enrollee, and to disclose on such form the amount of any extra fee(s) charged to the enrollee, or any portion of the scheduled fee(s) payable by the Plan that is remitted to the provider.

(e) Every participating medical service provider may at his or her own discretion advise any enrollees in advance of treatment that the provider will require the enrollee to pay a reasonable extra fee directly to the provider in addition to the fee payable by the Plan; and no such extra fee shall be charged by the provider or payable by the enrollee unless consented to by the enrollee in advance of treatment or if such extra fee would effectively prevent access by the enrollee to necessary medical treatment.

APPROVAL OF PATHOLOGICAL LABORATORIES

SEC. 18. (a) Every pathological laboratory that provides services which are covered benefits of the Plan and that desires to be listed by the Agency as a participating laboratory shall submit to the Agency in writing on an approved form an application for approval and listing, together with evidence of certification and licensure by all jurisdictional public health, safety, and business regulatory agencies and evidence of professional competence in the specific services offered.

(b) The Agency shall have final authority to issue a certificate of approval to a laboratory to provide specified services as benefits of the Plan and to list the laboratory as a provider of those specified services as benefits of the Plan.

(c) Any approved laboratory listed as a provider of specified services may from time to time request approval as a provider of other specific services or may request to be delisted as a provider of a specific service.

(d) The Agency shall have authority to withdraw approval and listing of a laboratory as a provider of specified services at any time the Agency has evidence of a lack of professional competence by the laboratory in specified services.

PARTICIPATION BY APPROVED LABORATORIES

SEC. 19. (a) Every laboratory which is approved and listed by the Agency as a provider of specified services shall be required to submit a correctly completed official claim form to the Plan on account of all such specific services provided to an enrollee at the request of the enrollee's doctor and shall not bill the enrollee for any additional fee for such service.

(b) Every laboratory which is approved and listed by the Agency as a provider of specified services shall be supplied without charge by the Agency with a Plan account number, all necessary claim submission forms, a schedule of all professionally recognized pathological laboratory services and related usual customary, and reasonable fees general informational material concerning the plan, and two durable display signs at least twenty-four by fourteen inches in size stating the name of the laboratory, the name and professional title of the supervising medical doctor, and the following wording: "This laboratory is a participating provider in the National Voluntary Medical and Hospital Services Insurance Plan and your valid Plan premium receipt will be accepted for submission of our claim for payment to the Plan. No other charge will be made to you for any service we provide that is a covered benefit of the Plan. We are approved by the Plan to provide the following services only: ————————————————.".

APPROVAL OF HOSPITALS

SEC. 20. Every hospital that provides services which are classed as benefits of the Plan shall be required to submit to the Agency in writing on an approved form an application for approval as a provider together with evidence of certification and licensure by all jurisdictional public health, safety, and business regulatory agencies and a certified statement of ownership, directors, and officers, a detailed inventory of all assets and facilities, current financial condition and a summary of income expenditures, and operations for the preceding forty-eight calendar months, or since the commencement of operations, whichever is the shorter time, and the Agency shall have final authority to approve each hospital and list it as a provider.

PARTICIPATION OF HOSPITALS

SEC. 21. Every hospital that is approved by the Agency and listed as a provider of benefits of the Plan shall be required to submit a correctly completed official claim form to the Plan on account of all services which are covered benefits of the Plan and provided to any enrollee and shall not bill any enrollee for any additional charge for such service but may bill any enrollee for additional or optional services requested by the enrollee.

MEDICAL SERVICES SCHEDULE AND FEES

SEC. 22. (a) The Agency shall compile and publish a schedule of every professionally recognized and defined physical and mental disease or disorder and every related diagnostic and therapeutic service procedure or treatment and affix to each service a fee that is in proportion to the usual, customary, and reasonable fee for such service in each general area of the United States and its territories.

(b) The Agency shall consult with the medical professional association or society in each general area in the compilation of the schedule and affixing of fees as provided in section 22 (a).

(c) The Agency shall consult with the medical professional association or society in each general area in establishing the percentage of each scheduled fee that will be paid by the Plan for each scheduled service that is a benefit of the Plan.

(d) The Agency shall provide a copy of the medical service and fee schedule without charge to every participating medical service provider and shall make additional copies of the schedule available to participating providers and to the medical profession in general at reasonable charge.

(e) The Agency shall consult with the medical professional association or society in each area annually with respect to making appropriate revisions in the schedule of medical services and fees or the percentage of scheduled fees payable by the Plan to medical service providers.

PATHOLOGICAL LABORATORY SERVICE SCHEDULE AND FEES

SEC. 23. (a) The Agency shall compile and publish a schedule of every professionally recognized and defined laboratory pathological test and procedure and shall affix to each such service a fee that is in proportion to the usual, customary, and reasonable fee for such service in each general area of the United States.

(b) The Agency shall consult with the medical professional association or society, and with the pathological laboratory specialist association or society in each general area of the United States in the compilation of the schedule of services and fees as provided in section 23 (a).

(c) The Agency shall consult with the medical professional association or society, and with the pathological laboratory specialist association or society in each general area in establishing the percentage of each scheduled fee that will be paid by the Plan for each service that is a benefit of the Plan.

(d) The Agency shall provide a copy of the pathological laboratory service and fee schedule without charge to every approved and participating laboratory service provider and shall make additional copies of the schedule available to participating providers and to the medical profession in general at a reasonable charge.

(e) The Agency shall consult with the medical professional association or society and with the pathological laboratory specialist association or society in each area annually with respect to making appropriate revisions in the schedule of laboratory services and fees or the percentage of scheduled fees payable by the Plan to laboratory service providers.

HOSPITAL CHARGES AND RATES

SEC. 24. (a) The Agency shall provide each approved hospital with a schedule of per diem rates and charges that will be paid by the Plan to that hospital for each specified service or item that is a benefit of the Plan and which is ordered on behalf of an enrollee by an attending medical doctor, doctor of osteopathic medicine, doctor of podiatric medicine, or doctor of dental surgery having staff privileges in the hospital with the consent of the hospital, and who is attending the enrollee with service which is a benefit of the Plan.

(b) The per diem rates and charges for specified services and items to be paid by the Plan to each hospital shall be based on each hospital's certified annual financial and operating cost statement, including the cost of amortizing every capitalized asset owned or obligated by a hospital and reasonable interest on all bonded and secured debt obligated prior to the date of inception of the Plan, and a projected annual operating budget for each forthcoming calendar year.

(c) After the date of inception of the Plan, the rates and charges for specified services and items to be paid by the Plan to each approved hospital shall not include the cost of operation or amortization of any capital expenditure that has not been specifically approved in advance by the Agency with respect to the public interest that is likely to be served by such capital expenditure.

FORM OF CLAIM FOR BENEFITS OF PLAN

SEC. 25. (a) All claims for service by participating medical service, laboratory service, and hospital service providers shall be submitted to the Plan within sixty days of the last day of the month in which the service was provided or completed, and on a correctly completed form supplied by the Agency and which shall be printed on standard keypunch computer entry card approximately seven and three-eighths inches by three and one-fourth inches in size with a carbon insert and a tissue carbon for retention by the provider.

(b) All claims by all participating providers shall state the following items of information:

(1) Provider's name, address, and Plan account number.

(2) Provider's assignee of payment, if any.

(3) Jurisdictional medical professional association or society, or Professional Standards Review Organization.

(4) Enrollee's name, address, and Plan account number.

(5) Date of each separate service inclusive in time.

(6) Duration of each service in days, hours, and minutes.

(7) Place of service as: office, home, hospital, ER, OPC, or elsewhere.

(8) Sequential number of each separate service in related treatment.

(9) Schedule number of service, procedure, or item.

(10) Related scheduled fee or charge for service, procedure, or item.

(11) Percentage of scheduled fee payable by the Plan.

(12) Medical diagnosis or description of patient's complaint.

(13) Name of referring or admitting doctor or referred-to doctor.

(14) Certifying signature of attending doctor.

(c) In addition to the items of information specified in section 25(b), all medical service providers shall be required to state on their claim form the amount, if any, of extra fees charged the enrollee, or any portion of the scheduled fee(s) payable by the Plan that are remitted by a provider.

(d) All information on each claim submitted by each participating provider shall be keypunched for entry into a computer according to a program that will enable the generation of the following output:

(1) Itemized monthly or quarterly statement of all accepted claims and a total payment check for each provider.

(2) Itemized monthly statement for each enrollee showing all claimed services and amounts paid to providers on behalf of enrollee (s).

(3) Cumulative itemized statements showing the quantity and character of utilization of Plan benefits by each provider and each enrollee, for use by jurisdictional medical professional associations or societies in assessing individual and general patterns of medical and hospital practice and utilization of Plan benefits on a continuing basis, as provided in sections 28 (b) and 28 (c).

AUDITING OF CLAIMS

SEC. 26. (a) Every claim for service submitted by a participating provider and every claim by an enrollee for reimbursement for payment to a nonexcluded nonparticipating medical service provider, as provided in section 16, shall be audited by the Agency or its agents with respect to the validity of the information specified and required in section 25 (b); and when such information is lacking or found to be incorrect or invalid or if the claimed service is not a specified benefit of the Plan, the claim shall be so noted and returned to the claimant.

(b) The Agency or its agents during the auditing of any claim shall make no assessment of the medical validity, necessity, or legality of the service claimed as a benefit of the Plan; but where there is reasonable doubt of the medical validity, necessity, or legality of any such claimed service the claim shall be referred to the Directors of the Agency for assessment or reference to the jurisdictional medical professional association or society or PSRO for assessment and recommendation respecting acceptance and payment of the claim, as provided in section 28 (a).

PAYMENT OF CLAIMS

SEC. 27. (a) Every submitted claim for service that is a benefit of the Plan and which has been approved for payment by audit and which has not been referred for assessment as provided in section 26 (b), shall be paid by the Plan within forty-five days after the last day of the calendar month in which the claim was submitted by the provider or enrollee.

(b) When more than one claim for service is submitted by a participating provider or enrollee in any one month, all approved claims shall be consolidated in a single payment to the provider or enrollee within the period specified in section 27 (a).

ASSESSMENT OF CLAIMS AND UTILIZATION OF PLAN BENEFITS

SEC. 28 (a). The Directors of the Agency shall make final determination and assessment of the medical validity, necessity, and legality of any claimed service that is a benefit of the Plan and to this end may enter into an agreement from year to year with any jurisdictional medical professional association or society or established Professional Standards Review Organization (PSRO) in any general area of the United States to consult with and advise the Directors in making such determinations and assessments and approving or disapproving payment for claimed services.

(b) The Agency may enter into an agreement from year to year with any jurisdictional medical professional association or society or PSRO in any general area of the United States to periodically or continuously review and assess the cumulative and continuing utilization of Plan benefits by participating providers and enrollees and to continuously advise the Agency of any utilization of Plan benefits that appears to be illegal, excessive, unwarranted, medically unnecessary, or medically invalid according to applicable laws and the normal and accepted standards of medical practice in the area.

(c) To effectuate any agreement provided in section 28(b), the Agency shall provide the jurisdictional medical professional association or society or PSRO with cumulative summaries of all claims by each participating provider and enrollee for services that are benefits of the Plan and which are categorized according to the type and nature of the service.

(d) A jurisdictional medical professional association or society or PSRO under agreement as provided in sections 28(a) and 28(b) may recommend to the Directors of the Agency the application and nature of sanctions or disciplinary action against any participating provider or enrollee found to be utilizing the benefits of the Plan illegally, excessively, unwarrantedly, or without medical necessity or validity.

(e) In response to the recommendations of any jurisdictional medical professional association or society or PSRO, as provided in section 28(d), the Directors of the Agency shall have authority to order a temporary or permanent reduction in the percentage of scheduled fees or rates payable in the future to a participating provider or to temporarily or permanently exclude a medical or laboratory service provider from future participation in the Plan or to serve notice on an enrollee of a temporary or permanent reduction in the benefits of the Plan that will be reimbursable to or payable on behalf of enrollees.

(f) The Agency shall pay to any jurisdictional medical professional association or society or PSRO with which it has entered into an agreement as provided in sections 28 (a) and 28 (b), a negotiated fee in the amount of 0.5 per centum or more or less than 0.5 per centum of the total dollar amount of providers' or enrollees' claims reviewed during such three-month period.

STATEMENT OF BENEFITS PAID

SEC. 29. (a) The Agency shall deliver to each enrollee a statement listing every service claimed to have been provided to the enrollee and the amount paid to each provider on account of such claimed service during each month or quarter year, as provided in section 25 (d) (2).

(b) As a condition of enrollment in the Plan every enrollee shall be required to notify the Agency of any claims for service by any provider which the enrollee has reason to believe were not, in fact, provided; and such obligation shall be noted on all statements furnished to enrollees.

RIGHT OF RECOVERY

SEC. 30. Any other remedies or actions against providers and enrollees provided in this Act notwithstanding, the Agency shall have the right to proceed in law to recover from any provider or enrollee any amounts paid by the Plan for services or benefits claimed but not, in fact, provided or received, or which are determined to be services or benefits excluded from the Plan, or services provided by nonapproved or nonparticipating hospitals and laboratories, or by medical service providers excluded from the Plan by the Directors.

EXCLUSION OF PARTICIPANTS

SEC. 31. (a) The Agency shall have authority to temporarily or permanently exclude from participation in the Plan any enrollee or provider of laboratory or medical service found to have been made, with intent to defraud the Plan, any false claim for payment for service provided or received; or as provided in section 28 (e), and in addition to the right of recovery as provided in section 30.

(b) The Agency shall have authority to temporarily or permanently exclude from participation in the Plan any provider of medical services found to have charged any enrollee an extra fee of such amount as to effectively prevent that enrollee's access to medically necessary service; or to have acted in concert or by prior agreement with any other provider(s) of medical service to regularly and habitually charge enrollees a scale of extra fees in excess of scheduled fees payable by the Plan.

(c) Any exclusion order made by the Agency under section 28 (e), 31 (a), or 31 (b) may be appealed by the excluded party to the Directors or the Agency and thereafter to any jurisdictional State or Federal court at any time within one year of the effective date of such order.

(d) The Agency shall publish the names of every medical and laboratory service provider excluded from the Plan, as provided in sections 28 (e) and 31 (a) and shall advise each enrollee that they will not be reimbursed by the Plan for any service received from any excluded provider, except when such exclusion order is under appeal or revoked as provided in section 31 (b).

ADDITIONAL BENEFITS

SEC. 32. (a) Every paid-up enrollee in the Plan shall be entitled to reimbursement in the lesser amount of either the scheduled fee or charge payable by the Plan to a participating provider in the area of residence in the United States of the enrollee, or the actual fee or charge paid by the enrollee to a medical doctor, pathological laboratory, or general medical hospital outside of the United States or its territories for any service that ordinarily would be a benefit of the Plan in the United States or its territories while the enrollee was traveling outside of the United States or its territories or temporarily living in a foreign country for a period not exceeding one year from the enrollee's date of departure from the United States or its territories upon submission to the Agency of a valid receipted statement for such service and payment.

(b) The benefits provided in section 32 (a) shall apply to a child born outside of the United States or its territories to a mother who is an enrollee in the Plan, and who would otherwise be entitled to the benefits provided in section 32 (a), if the child is enrolled in the Plan and the applicable premium is paid on its behalf within thirty days of birth, as provided in section 15.

(c) Not less than two years after the effective date of inception of the Plan, the Agency Directors shall consider the advisability and feasibility of offering additional benefits to enrollees, such as but not necessarily including or limited to payment or reimbursement for dental service, prescribed drugs, prosthetics, home nursing and podiatric medicine outside of hospital; chiropractic treatment; and Christian Science healing; on a basis of full or partial cost or a scheduled annual amount, to be included within the established premiums of the Plan or in consideration of additional and optional premiums; and shall bring their recommendations before the Congress for appropriate amendment of this Act.

Sec. 33. Not less than three years after the effective date of inception of the Plan, the Directors of the Agency may recommend to the Congress an appropriate increase in the schedule of premiums set out in section 10 (a) and 10 (b), if it is then found that the actual costs of medical, laboratory and hospital services that are benefits of the Plan exceed the apportioned and reserved income from subscribers' premiums, as provided in section 13 (a), and matching appropriations of United States Treasury funds, as provided in section 13 (b).

AMENDMENT OF THE SOCIAL SECURITY ACT

SEC. 34. When this Act becomes operative through the signature of the President, the Congress shall enact a separate Act amending the effective rates of employee, employer, and self-employed taxation imposed by the Social Security Act, in consideration of and relative to the reduction in expenditures on the health insurance functions of all programs provided by the Social Security Act, and which will cease to be operative, as provided by section 6 (a), when this Act becomes operative.

ARBITRATION

SEC. 35. (a) It shall be a condition of enrollment and participation in the Plan that every enrollee and provider shall agree to refer every claim or demand for damages resulting from alleged negligence or malpractice in the provision of any service that is a benefit of the Plan, for arbitration to an arbitration board comprised of one licensed medical doctor and one licensed attorney nominated by the complainant (s) together and severally, and one licensed medical doctor and one licensed attorney nominated by the defendant (s) together and severally, and one licensed medical doctor nominated by the jurisdictional medical professional association or society, and one licensed attorney nominated by the jurisdictional bar association or society.

(b) All sessions of the board of arbitration provided in section 35 (a) shall be chaired by the attorney nominated by the jurisdictional bar association or society, and shall be held in quarters provided by the Agency.

(c) The medical doctor nominated to the board of arbitration by the jurisdictional medical professional association or society shall participate in the questioning and discussions of each session but shall not have a vote in any final decision or ruling by the board.

(d) A majority of the voting members of a board of arbitration, as provided in sections 35 (a) and 35 (c), shall determine and assess the degree of and responsibility for negligence or culpable malpractice, if any, by the defendant (s) together or severally and the amount of damages, if any, sustained by the complainant (s) together or severally as a consequence of such negligence or culpable malpractice, if any, by the defendant (s) together or severally.

(e) If a board of arbitration, as provided in section 35 (a), (b), (c), and (d), finds that complainant (s) together or severally have sustained an amount of damages as a consequence of the negligence or culpable malpractice by the defendant (s) together or severally, in the provision of any service that is a benefit of the Plan, the Agency shall pay to the complainant(s) together or severally the amount of all damages so determined and assessed, in full settlement of the complainant(s) claim, unless the findings of the board of arbitration are appealed as provided in section 35(i).

(f) The Agency shall have the right to and shall endeavor by every means and recourse provided by law to recover from any defendant(s) together or severally any amounts of damages paid to any complainant(s) together or severally as provided in section 35(e), together with any sessional fees paid to the members of the board of arbitration as provided in section 35(g), subject to appeal as provided in section 35(i); and to this end may withhold all or any portion of any payments due the defendant(s) together or severally for past or future services that are benefits of the Plan.

(g) The Agency shall enter into an agreement with each member nominated to a board of arbitration, as provided in section 35(a), to pay each such member a sessional fee in the amount of $35 per hour or more or less than $35 per hour for each hour or portion of an hour devoted by each member to his duties on the board of arbitration.

(h) If the majority of voting members of a board of arbitration, as provided in sections 35(a) and 35(c), find that any allegation of negligence or malpractice or any claim for damages by complainant (s) together or severally is wholly without merit or capricious or malicious, the Agency shall have the right to, and shall endeavor to, recover by every means and recourse in law from the complainant (s) together or severally the amounts of all sessional fees paid to members of the board of arbitration as provided in section 35 (g).

(i) Any finding or assessment by a board of arbitration as provided in sections 35 (d) and 35 (h) may be appealed to any jurisdictional State or Federal court by the defendant (s) together or severally or the complainant (s) together or severally or by the Directors of the Agency if damages are assessed and payable to complainant (s) together or severally as provided in section 35 (e).

LIMITED SCOPE OF PLAN

SEC. 36. The purpose of this Act is to provide only for the establishment of a national voluntary insurance Agency and Plan to pay all reasonable costs of all necessary and appropriate medical, pathological laboratory and hospital services, and such other additional benefits as may be added in the future, as provided in section 32, for all enrollees when and where such services are available from approved, participating and nonexcluded providers; and the resources of the Agency and Plan shall not be used in any way directly to regulate the quality or availability of, or to establish or operate, such services; and if adequate services are not available when and where required by enrollees, the Agency and Plan shall have no responsibility or liability to provide such services; and in consideration of the aforestated limited scope and purpose of this Act, enrollment in and subscription to the Plan shall be voluntary for all enrollees and subscribers as provided in section 14; and by so limiting the scope and purpose of this Act to the providing of economic access to presently available health services, any deficiencies in the quality, quantity, methods, economics, and distribution of those services should be clearly revealed and may then be corrected or improved by the health care profession or appropriate public or private agencies, outside of and separate to the National Voluntary Medical and Hospital Services Insurance Plan and Agency.

ESTIMATED COST OF PLAN (1975 COST LEVELS)

SEC. 37. (a) It is estimated that this Act would provide total medical and hospital care for all Americans at substantially less cost than present public expenditures for these services, for a limited segment of the population only, through the medicare and medicaid programs, which would be largely eliminated as follows:

(b) Federal medicare/medicaid costs:

Federal medicare/medicaid costs eliminated	$18,100,000,000
State medicaid costs eliminated	5,000,000,000
Total Federal and State savings	23,000,000,000

(c) Maximum anticipated average enrollment in Plan during first three years of operation: one hundred million; at average monthly premiums of $9 per capita ($108 per year) or a total of less than $11,000,000,000 per year; requiring matching United States Treasury general funds.

(d) Maximum anticipated enrollment in Plan during fourth and subsequent years: Two hundred million, at average monthly premiums of $9 per capita ($108 per year) or a total of less than $22,000,000,000 per year; requiring matching United States Treasury general funds.

(e) If all States opted to pay minimum-level premiums ($30 per year, per capita, average) for all persons receiving public welfare assistance (twenty million estimated) the total cost would be approximately $600,000,000.

(f) Cost of medical benefits of Plan: under assumed maximum utilization by two hundred million enrollees and two hundred and twenty-five thousand providers (a ratio of 890:1) 35 per centum of Plan trust funds reserved for medical benefit would amount to approximately $15,000,000,000 per year, or an average of approximately $65,000 per doctor, per year.

(g) Cost of hospital benefits of Plan: Under assumed maximum utilization by two hundred million enrollees, 62 per centum of Plan trust funds reserved for hospital benefits would amount to approximately $27,000,000,000 for payments to community hospitals ($135 per enrollee, per year, average).

94th CONGRESS
1st Session

H. R. 4747

IN THE HOUSE OF REPRESENTATIVES

March 12, 1975

Mr. Carter introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Social Security Act to provide adequate financing of health care benefits for all Americans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Health Insurance Act of 1974".

TITLE I—NATIONAL HEALTH CARE BENEFITS PROGRAM

Sec. 101. The Social Security Act is amended by striking out title XVIII and inserting in lieu thereof the following new title XVIII:

I—O

"TITLE XVIII—HEALTH CARE BENEFITS

"FINDINGS AND DECLARATION OF PURPOSE

"SEC. 1800. (a) The Congress hereby finds that—

"(1) many Americans are not now receiving adequate health care because of inability to pay the cost of such care;

"(2) the lack of adequate protection against the cost of health care prevents or seriously interferes with the ability of many Americans to secure necessary health care for themselves and their families or requires them to deplete their resources substantially or completely in order to secure such care;

"(3) the high cost and lack of urgency associated with preventive services often deter individuals from seeking services which are vital to improving health and controlling costs;

"(4) as a result, the national health is seriously and adversely affected and this in turn seriously affects the general welfare;

"(5) to protect the national health and, consequently, the general welfare, it is necessary to assure that adequate protection against the cost of necessary health care is provided by requiring employers to provide health care plans for their employees and assisting the States to provide health care plans for persons to whom employee health care plans are not available; and

"(6) to require this only of employers engaged in interstate commerce would impose an unreasonable burden on such commerce.

"(b) It is therefore the purpose of this title to provide adequate protection against these costs by requiring all employers to offer health care plans to their employees; and to assist the States in making similar plans available to individuals in need of such protection.

"PART A—EMPLOYEE HEALTH CARE BENEFITS

"HEALTH CARE PLANS REQUIRED

"SEC. 1801. (a) Every employer shall provide to each of his employees under the age of 65 whose place of employment is in a State certified by the Secretary under section 1861, and who was employed by him for not less than—

"(A) 25 hours per week for 10 weeks, or

"(B) 350 hours,

in the preceding 13 consecutive calendar weeks, a reasonable opportunity, as determined under regulations prescribed by the Secretary, to obtain coverage for himself and the members of his family under the age 65 under, at the option of the employee—

"(1) an employee health care insurance plan approved under this title or associated health care insurance plan obtained by the employer pursuant to part B, "(2) a group practice prepaid health care plan approved under this title, or

"(3) an individual practice prepaid health care plan approved under this title,

except that the Secretary may by regulation specify circumstances in which an employer need not offer an employee an opportunity to obtain coverage under a group practice or individual practice prepaid health care plan because such a plan is not available. The employer must offer the same health care plans to all employees in the same locality, as determined under regulations prescribed by the Secretary, except for such exceptions as the Secretary may, by regulation, provide. For purposes of the first sentence of this subsection, there shall be counted only those hours of service performed within the United States or service performed outside the United States by an American citizen for an American employer.

"(b) An employer who has an employee to whom he is required to provide the opportunity to obtain coverage under a health care plan under subsection (a) shall provide the same opportunity to each of his employees employed at the same place of employment who is not otherwise entitled to that opportunity because of the hours of work requirement imposed under subsection (a) and was employed by him for not less than 25 hours in the preceding calendar week.

"(c) Any bargaining agent recognized as an exclusive bargaining agent under the laws of the United States or any State, may exercise, on behalf of the employees for whom it is recognized as the exclusive bargaining agent, the options which must be offered to employees under this section, including the option to decline coverage under any health care plan approved under this title or provided pursuant to part B.

"EMPLOYER CONTRIBUTIONS

"SEC. 1802. (a) An employer required by section 1801 (a) to provide an employee the opportunity to obtain coverage for himself and the members of his family under the age of 65 under a health care insurance plan shall, if the employee obtains such coverage, contribute to the cost of that coverage, during the period that the employer is required by section 1801 (a) to provide the opportunity to obtain coverage under the plan, and for 90 days after the employer is no longer required by section 1801 (a) to provide that opportunity, an amount equal to at least 75 percent of the cost of that coverage, as determined under regulations prescribed by the Secretary. An employer must pay the contributions required by this section, in the case of a plan provided by a carrier, directly to the carrier of an employee health and welfare fund.

"(b) An employer required by section 1801 (a) to provide an employee the opportunity to obtain coverage for himself and the members of his family under the age of 65 under a prepaid health care plan shall, if the employee obtains that coverage, contribute to the cost of that coverage, during the period that the employer is required by section 1801 (a) to provide the opportunity to obtain coverage under the plan and for 90 days after the employer is no longer required by section 1801 (a) to provide that opportunity, an amount equal to the amount he would be required to contribute under subsection (a) to coverage under a health care insurance plan.

"INFORMATION FOR EMPLOYEES

"Sec. 1803. An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall advise the employee of the plans and arrangements for the financing or provision of health care offered by the employer, the benefits they provide, their cost, and the means by which coverage under any of them can be secured. The employer shall also provide the employee with information concerning the availability of health care benefits pursuant to part B.

"UNAPPROVED PLANS PROHIBITED

"Sec. 1804. An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall neither provide that employee with an opportunity to secure, nor contribute toward the cost of, coverage under any plan or arrangement for the financing or provision of health care other than a health care insurance plan approved under this title or obtained pursuant to part B or a prepaid health care plan approved under this title, except that—

"(1) the employer may offer the employee the opportunity to obtain coverage under a special employee health care program approved under this title, and

"(2) the employer may offer the employee the opportunity to obtain coverage under a plan or arrangement for the financing or provision of health care not approved under this title or obtained under part B if acceptance of coverage under the plan or arrangement is not a condition of obtaining coverage under any health care plan offered by the employer pursuant to section 1801 and the employee has obtained coverage under such a health care plan.

"DISCRIMINATION ON THE BASIS OF HEALTH STATUS PROHIBITED

"SEC. 1805. (a) No employer may discriminate against an individual with respect to the opportunity for employment, or the compensation, terms, condition, or privileges of employment, because of the individual's health status or the health status of his dependents, except when directly related to the capacity of the individual to perform his duties as an employee.

"(b) An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall not offer the employee a financial inducement to, or condition the employee's employment on, rejection of coverage under the plan.

"EXCLUDED EMPLOYERS

"SEC. 1806. The provisions of this section shall not apply to the United States Government, the government of the District of Columbia, a foreign government, or an international organization described in section 210(a) (15), or any agency or instrumentality of such a government or organization.

"PART B—GRANTS TO STATES FOR HEALTH CARE BENEFITS PROGRAMS

"APPROPRIATION

"SEC. 1821. For the purpose of assisting each State to provide adequate health care benefits to individuals who are otherwise unable to obtain such benefits, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for provision of health care benefits.

"STATE PLANS FOR PROVISION OF HEALTH CARE BENEFITS

"SEC. 1822. (a) A State plan for the provision of health care benefits must—

"(1) provide that—

"(A) the members of any family residing in the State who are not entitled to Federal health care benefits under part C of this title, are not covered under a health care plan pursuant to part A of this title, and have an aggregate annual income of less than—

"(I) 52.5 percent of the income class base, as determined under section 1825(b)(5), in the case of a one member family group, or

"(II) 75 percent of that income class base, in the case of a more than one member family group; and

"(B) the members of any family residing in the State who are not entitled to health care benefits under part C of this title and are not eligible for coverage under a health care plan pursuant to part A;

shall be eligible for health care benefits under the plan;

"(2) provide that any employer subject to the requirements of part A of this title shall be eligible to obtain health care benefits under the plan for the purpose of providing such benefits, pursuant to the requirements of part A, to his employees whose place of employment is within the State;

"(3) provide that the benefits under the plan for any family group described in clause (1) shall be the opportunity for the family group—

"(A) to obtain coverage under an assisted health care insurance plan, or

"(B) at the option of the family group, to have the State pay to any prepaid health care plan approved under this title under which the family group has obtained coverage at a rate which the State determines is reasonable, on behalf of the family group, an amount equal to the cost to the State of providing coverage under an assisted health care insurance plan, as determined under regulations prescribed by the Secretary;

"(4) provide that the benefits provided to an employer described in clause (2) shall be—

"(A) the opportunity for each employee of the employer whose place of employment is within the State, and to whom the employer is required by part A to offer the opportunity to obtain coverage under a health care insurance plan, to obtain coverage for himself and the members of his family under the age of 65 under an assisted health care insurance plan, and

"(B) in the case of any such employee who elects instead to obtain coverage under a prepaid health care plan made available by the employer pursuant to part A of this title at a rate which the State determines is reasonable, to have the State pay to such plan, on behalf of the employer and employee, an amount equal to the cost to the State of providing coverage under an assisted health care insurance plan, as determined under regulations prescribed by the Secretary;

"(5) provide that the eligibility of family groups for benefits under the plan, the premium, deductible, coinsurance, and related requirements applicable to eligible family groups, and the eligibility of employers to obtain benefits under the plan shall be determined by the public agency designated by the Secretary;

"(6) provide that the opportunity to obtain coverage under an assisted health care insurance plan shall be provided (A) through arrangements with one or more carriers pursuant to which—

"(I) the carrier will offer coverage under the plan to all eligible family groups and offer to provide the plan to all eligible employers, and

"(II) the State will pay the carrier an amount equal to payments made by the carrier under the plan and the cost of necessary and proper administration, less any premium, deductible, and coinsurance payments and other amounts received by the carrier in connection with administration of the plan, as determined under regulations prescribed by the Secretary,

or, (B) directed by the State if the Secretary so authorizes;

"(7) provide that any premium, deductible, or coinsurance payment or other amounts owed to the State or paid by the State pursuant to an arrangement with a carrier shall be a debt owed to the State, and that the State shall make reasonable efforts to collect such debts;

"(8) provide that if any member of a family group described in clause (1) (A) which is receiving health care benefits under the plan is an employee to whom an employer is required by section 1801 to offer the opportunity to obtain coverage under a health care insurance plan, the employer shall be required to pay the State the amount the employer would be required to contribute if the employee obtained coverage under the health care insurance plan offered by the employer;

"(9) provide that the State will, in the third quarter of each calendar year, determine, in accordance with regulations prescribed by the Secretary, the estimated average premium for coverage for the succeeding calendar year, in the State, under an employee health care insurance plan approved under this title, of an employee with one or more family members under the age of 65;

"(10) provide that the State will comply with such requirements as the Secretary may, by regulation, impose for the purpose of assuring cooperation among the States in the administration of State plans approved under this part;

"(11) provide that the State will not impose any premium tax on any premiums for health care plan coverage obtained under the State plan;

"(12) provide that the State will comply, and will require any carrier participating in the administration of the State plan to comply, with such requirements as the Secretary may, by regulation, prescribe for the purpose of controlling access to information obtained in connection with administration of the State plan;

"(13) provide that the State will make such reports, in such form and containing such information, as the Secretary may require, and comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(14) contain such other provisions as the Secretary may determine are necessary to carry out the purposes of this part.

"(b) The Secretary shall approve any plan submitted by a State certified by the Secretary under section 1861 which fulfills the requirements specified in subsection (a).

"(c) The Secretary shall, by regulation, prescribe the criteria and standards for determining the State of residence of family groups for purposes of this part, which regulations shall provide that each family group residing in the United States shall have a State of residence.

"PAYMENT TO STATES

"SEC. 1823. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 1976, an amount equal to the net expenditures under the State plan during that quarter, less

"(A) the State contribution for that quarter, and

"(B) an amount which bears the same ratio to the payments made during that quarter under part C with respect to individuals described in section 1831(a) in income classes I, II, and III who reside in the State which would not have been made if those individuals were in income class IV, as the State contribution for that quarter bears to the net expenditures under the State plan during that quarter.

"(b) (1) For purposes of subsection (a), the net expenditures under a State plan during any quarter shall be the total amount expended during that quarter under the State plan, including amounts found necessary by the Secretary for proper and efficient administration of the plan, less the total of the debt payments, employer payments, and other amounts received by the State during that quarter in connection with administration of the plan.

"(2) For purposes of subsection (a), the State contribution for any quarter in the first calendar year in which there is in effect in the State a plan approved under this part shall be—

"(A) one-fourth of the total non-Federal expenditures, other than expenditures related to the provision of skilled nursing home facility services, home health services, intermediate care facility services, inpatient hospital services in institutions for mental diseases and psychiatric hospitals, and dental services, under the plan of the State approved under title XIX for fiscal year 1975; plus

"(B) 10 percent of the product of—

"(I) the per capita income of the State divided by the per capita income of the United States; and

"(II) the net expenditures under the State plan during that quarter (as determined under paragraph (1)), less one-fourth of the total Federal and non-Federal expenditures, other than expenditures related to the provision of skilled nursing home facility services, home health services, intermediate care facility services, inpatient hospital services in institutions for mental diseases and psychiatric hospitals, and dental services, under the plan of the State approved under title XIX for fiscal year 1975.

"(3) For purposes of subsection (a), the State contribution for any quarter in a calendar year beginning after the first calendar year in which there is in effect in the State a plan approved under this part shall be—

"(A) one-fourth of the State contribution under the plan of the State approved under this part for the first calendar year in which there is in effect in the State a plan approved under this part; plus

"(B) 25 percent of the product of—

"(I) the per capita income of the State divided by the per capita income of the United States; and

"(II) the net expenditures under the State plan during that quarter (as determined under paragraph (1)), less one-fourth of the net expenditures under the State plan during the first calendar year in which there is in effect in the State a plan approved under this part.

"OPERATION OF STATE PLANS

"SEC. 1824. If the Secretary, after reasonable notice and an opportunity for hearing to a State which has a plan approved under this part, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1822; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"REQUIREMENTS FOR ASSISTED HEALTH CARE INSURANCE PLANS

"SEC. 1825. (a) An assisted health care insurance plan must meet all of the requirements for approval of an employee health care insurance plan contained in section 1841, other than the requirements contained in subsections (c), (d), (e), (f), (g) (6), (g) (7), (g) (8), and (h) thereof.

"(b) (1) An assisted health care insurance plan must charge as a premium for each calendar year an amount equal to the following percentages of the estimated average premium for coverage for such year, in the State, under an employee health care insurance plan approved under this title, of an employee and the members of his family under the age of 65—

"(A) in the case of family groups described in section 1822 (a) (1) in income class III, 20 percent for one member groups, and 50 percent for more than one member groups;

"(B) in the case of family groups described in section 1822 (a) (1) in income class IV, 40 percent for one member groups, and 100 percent for more than one member groups;

"(C) in the case of family groups described in section 1822 (a) (1) in income class V, 60 percent for one member groups, and 150 percent for more than one members groups; and

"(D) in the case of employees of employers described in section 1822 (a) (2), 60 percent for employees without any family members under the age of 65, and 150 percent for employees with one or more family members under the age of 65.

No premium shall be charged in the case of family groups described in section 1822 (a) (1) in income classes I and II.

"(2) (A) An assisted health care insurance plan must, subject to paragraph (4), impose, with respect to all items and services, other than outpatient drugs and biologicals, other blood and blood products, and items and services described in clauses (i) through (viii) of section 1841 (a) (2) (A), a per individual per calendar year deductible equal to the following percentages of the deductible base—

"(I) in the case of family groups described in section 1822 (a) (1) in income class II, 33⅓ percent;

"(II) in the case of family groups described in section 1822 (a) (1) in income class III, 66⅔ percent; and

"(III) in the case of family groups described in section 1822 (a) (1) in income classes IV and V, and employees of employers described in section 1822 (a) (2), 100 percent;

except that no further deductible shall be imposed under this paragraph in any calendar year after three members of a covered family group or employee and his family satisfy the deductible requirement for that year. No such deductible shall be imposed in the case of family groups described in section 1822 (a) (1) in income class I.

"(B) The plan must, subject to paragraph (4), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual per calendar year deductible equal to the following percentages of the deductible base—

"(I) in the case of family groups described in section 1822 (a) (1) in income class II, $16\frac{2}{3}$ percent; and

"(II) in the case of family groups described in secton 1822 (a) (1) in income classes III, IV, and V, and employees of the employers described in section 1822 (a) (2), $33\frac{1}{3}$ percent.

No such deductible shall be imposed in the case of family groups described in section 1822 (a) (1) in income class I.

"(C) The plan must impose, with respect to blood and blood products, such deductible as the Secretary may, by regulation, prescribe.

"(D) The deductible base shall be $150 for calendar years 1976 and 1977, and the amount determined under subparagraph (E) for years after 1977.

"(E) The Secretary shall, during November of 1977 and of each year thereafter, determine and promulgate the per individual deductible to be applied under this paragraph for the following calendar year. The deductible shall be computed by increasing or decreasing $150 by the same percentage (rounded to the nearest one-tenth of 1 percent) by which the actuarial value of an employee health care insurance plan approved under this title for the year in which the determination is made exceeds or is less than such actuarial value for calendar year 1976. If the deductible derived from such computation is not a multiple of $6, it shall be reduced to the next lower multiple of $6.

"(3) An assisted health care insurance plan must impose, subject to paragraph (4), a coinsurance requirement equal to—

"(A) in the case of family groups described in section 1822 (a) (1) in income class I, 10 percent;

"(B) in the case of family groups described in section 1822 (a) (1) in income class II, 15 percent;

"(C) in the case of family groups described in section 1822 (a) (1) in income class III, 20 percent; and

"(D) in the case of family groups described in section 1822 (a) (1) in income classes IV and V, and employees of employers described in section 1822 (a) (2), 25 percent;

of expenses (other than expenses for items and services described in clauses (i) through (viii) of section 1841 (a) (2) (A)) in excess of any applicable deductible.

"(4) An assisted health care insurance plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals the following percentages of annual income—

"(A) in the case of family groups described in section 1822 (a) (1) in income class I, 6 percent;

"(B) in the case of family groups described in section 1822 (a) (1) in income class II, 9 percent;

"(C) in the case of family groups described in section 1822 (a) (1) in income class III, 12 percent; and

"(D) in the case of family groups described in section 1822 (a) (1) in income class IV, 15 percent.

In the case of family groups described in section 1822 (a) (1) in income class V, and employees of employers described in section 1822 (a) (2), the plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals 10.5 percent, in the case of one member family groups and employees without any family members under the age of 65, or 15 percent, in the case of more than one member family groups and employees with one or more family members under the age of 65, of the income class base for that calendar year, as determined under paragraph (5). The plan must provide that any deductible or coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to this part or part C will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan have been met.

"(5) (A) The income class of a family group described in section 1822 (a) (1) for calendar year must be determined on the basis of the family group's income for that year.

"(B) In the case of one member family groups, the income limits of the classes must be—

"(I) for income class I, less than 17.5 percent of the income class base;

"(II) for income class II, at least 17.5 percent of the income class base, but less than 35 percent of that base;

"(III) for income class III, at least 35 percent of the income class base, but less than 52.5 percent of that base;

"(IV) for income class IV, at least 52.5 percent of the income class base, but less than 70 percent of that base; and

"(V) for income class V, at least 70 percent of the income class base.

"(C) In the case of more than one member family groups, the income limits of the classes must be—

"(I) for income class I, less than 25 percent of the income class base;

"(II) for income class II, at least 25 percent of the income class base, but less than 50 percent of that base;

"(III) for income class III, at least 50 percent of the income class base, but less than 75 percent of that base;

"(IV) for income class IV, at least 75 percent of the income class base but less than 100 percent of that base; and

"(V) for income class V, at least 100 percent of the income class base.

"(D) The income class base shall be $10,000 for calendar years 1976 and 1977, and the amount determined under subparagraph (E) for years after 1977.

"(E) The Secretary shall, during November 1977 and of each year thereafter, determine and promulgate the income class base to be applied under this paragraph for the following calendar year. The base shall be computed by increasing or decreasing $10,000 by the same percentage (rounded to the nearest one-tenth of 1 percent) by which the average of the taxable wages of all employees as reported to the Secretary under title II for the first quarter of the calendar year in which the determination is made exceeds or is less than such average for the first quarter of calendar year 1976. If the base derived from such computation is not a multiple of $100, it shall be reduced to the next lower multiple of $100.

"(c) An assisted health care insurance plan must provide that coverage under the plan will continue to be available to a covered employee of an employer described in section 1822(a)(2), and the members of his family under the age of 65, to whom the plan is offered pursuant to section 1801(a) for 180 days after the employer is no longer required by section 1801(a) to offer the plan to the employee, at the same premium rate at which coverage under the plan is available to employees of the employer.

"(d) An assisted health care insurance plan must provide—

"(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

"(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full and associate participating providers for all items and services without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those limitations and deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that an account will not be regarded as in default unless payment of amounts due under the account, or any other such account established with respect to the covered individual pursuant to the requirements of this title, is 90 days in arrears.

"PART C—FEDERAL HEALTH CARE BENEFITS PROGRAM

"ELIGIBILITY FOR AND NATURE OF BENEFITS

"SEC. 1831. (a) (1) The Secretary shall establish a Federal health care benefits program under which an individual residing in a State certified by the Secretary under section 1861 who—

"(A) has attained the age of 65, and

"(B) is entitled to monthly insurance benefits under section 202, or would be entitled, upon application, to such benefits if all employment subject to the taxes imposed by sections 3101 (b) and 3111 (b) of the Internal Revenue Code of 1954 were covered employment for the purpose of determining entitlement to such benefits, or is a qualified railroad retirement beneficiary,

shall be entitled to Federal health care benefits under part C of title XVIII.

"(2) For purposes of paragraph (1)—

"(A) an individual shall be deemed entitled to monthly insurance benefits under section 202, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month, and

"(B) the term 'qualified railroad retirement beneficiary' means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board on the month in which he ceased to meet the requirements of section 21 of the Railroad Retirement Act of 1937.

"(b) The benefits provided under the program shall be the opportunity, at the option of the individual—

"(1) to obtain coverage under the Federal health care insurance plan, or

"(2) to have the Secretary pay to any prepaid health care plan approved under this title under which the individual has obtained coverage at a rate which the Secretary determines is reasonable, on behalf of the individual, an amount equal to the cost to the Government of providing coverage under a Federal health care insurance plan, as determined under regulations prescribed by the Secretary.

"FEDERAL HEALTH CARE INSURANCE PLAN

"SEC. 1832. (a) The Federal health care insurance plan shall be an insurance plan which meets all the requirements for approval of an employee health care insurance plan contained in section 1841, other than the requirements contained in subsections (c), (d), (e), (f), (g) (6), (g) (7), (g) (8), (g) (9), and (h) thereof.

"(b) (1) The Federal health care insurance plan shall charge as a premium for each calendar year an amount equal to 15 percent of the amount which the Secretary determines is the estimated average cost of coverage for that year under the plan of an individual in income class IV, except that no premium shall be charged in the case of individuals in income classes I and II. Premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulation provide. All premium payments shall be deposited in the Treasury to the credit of the Federal Health Care Benefits Trust Fund.

"(2) (A) The Federal health care insurance plan shall, subject to paragraph (4), impose with respect to all items and services, other than outpatient drugs and biologicals, other blood and blood products, and items and services described in clauses (i) through (viii) of section 1841 (a) (2) (A), a per individual per calendar year deductible equal to the following percentages of the deductible base, as determined under section 1825 (b) (2)—

"(I) in the case of individuals in income class II, 33⅓ percent; and

"(II) in the case of individuals in income classes III, IV, and V, 66⅔ percent.

No such deductible shall be imposed in the case of individuals in income class I.

"(B) The plan shall, subject to paragraph (4), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual per calendar year deductible equal to the following percentages of the deductible base, as determined under section 1825(b)(2)—

"(I) in the case of individuals in income class II, 16⅔ percent; and

"(II) in the case of individuals in income classes III, IV, and V, 33⅓ percent.

No such deductible shall be imposed in the case of individuals in income class I.

"(C) The plan shall impose, with respect to blood and blood products, such deductible as the Secretary may, by regulation, prescribe.

"(3) The Federal health care plan must impose, subject to paragraph (4), a coinsurance requirement equal to—

"(A) in the case of individuals in income class I, 10 percent;

"(B) in the case of individuals in income class II, 15 percent; and

"(C) in the case of individuals in income classes III, IV, and V, 20 percent;

of expenses (other than expenses for items and services described in clauses (i) through (viii) of section 1841(a)(2)(A) in excess of any applicable deductible.

"(4) The Federal health care insurance plan shall provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals the following percentages of annual income—

"(A) in the case of individuals in income class I, 6 percent;

"(B) in the case of individuals in income class II, 9 percent; and

"(C) in the case of individuals in income class III, 12 percent.

In the case of individuals in income classes IV and V, the plan shall provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals 7.5 percent of the income class base for that calendar year, as determined under section 1825(b)(5). The plan shall provide that any deductible or coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to part B will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan have been met.

"(5) The income class of an individual shall be determined on the basis of the same standards as those prescribed in section 1825(b)(5) for the determination of the income class of a family group described in section 1822(a)(1), with an individual being considered, for that purpose, a one member family group.

"(c) The Federal health care insurance plan shall provide—

"(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

"(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full and associate participating providers for all items and services without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those limitations and deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that an account will not be regarded as in default unless payment of amounts due under the account, or any other such account established with respect to the covered individual pursuant to the requirements of this title, is 90 days in arrears.

"USE OF CARRIERS IN ADMINISTRATION OF FEDERAL HEALTH CARE INSURANCE PLAN BENEFITS

"SEC. 1833. (a) The Secretary is authorized to enter into contracts with carriers for the administration of benefits under the Federal health care insurance plan. Each such contract shall contain such terms and conditions not inconsistent with this part as the Secretary may find necessary or appropriate.

"(b) (1) Contracts with carriers under this section may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

"(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

"(3) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with efficient and effective administration of the program established by this part.

"(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under the Federal health care insurance plan, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

"(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(e) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer described in paragraph (1) of this subsection.

"SOURCE OF PAYMENTS TO PROVIDERS OF SERVICES AND PREPAID HEALTH CARE PLANS

"SEC. 1834. The Secretary shall pay the amounts which he determines should be paid under this part to providers of items and services and prepaid health care plans, prior to audit or settlement by the General Accounting Office, from the Federal Health Care Benefits Trust Fund.

"FEDERAL HEALTH CARE BENEFITS TRUST FUND

"SEC. 1835. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Federal Health Care Benefits Trust Fund (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201 (i) (1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1976, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of—

"(1) the taxes imposed by section 3101 (b) and 3111 (b) of the Internal Revenue Code of 1954 with respect to wages from employment in States certified by the Secretary under section 1861 reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1975, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

"(2) the taxes imposed by section 1401 (b) of the Internal Revenue Code of 1954 with respect to self-employment income earned in States certified by the Secretary under section 1861 reported to the Secretary of the Treasury of his delegate on tax returns under subtitle F of such Code after December 31, 1975, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

"(1) hold the Trust Fund;

"(2) report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

"(3) report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 percent, the rate of interest on such obligations shall be the multiple of one-eighth of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accured interest.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

"(f) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201 (g) (1).

"AUTHORIZATION OF APPROPRIATIONS TO THE TRUST FUND

"SEC. 1836. There is authorized to be appropriated to the Federal Health Care Benefits Trust Fund from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

"(1) payments made or to be made during the fiscal year from the Trust Fund with respect to individuals described in section 1831 (a) in income classes I, II, and III which would not have been made or would not be made if those individuals were in income class IV,

"(2) the additional administrative expenses resulting or expected to result from the making of those payments, and

"(3) any loss in interest to the Trust Fund resulting from the making of those payments,

in order to place the Trust Fund, at the end of the fiscal year, in the same position in which it would have been if those payments had not been made.

"PART D—REQUIREMENTS FOR APPROVAL OF HEALTH CARE PLANS AND SPECIAL EMPLOYEE HEALTH CARE PROGRAMS AND FOR CERTIFICATION OF PROVIDERS

"REQUIREMENTS FOR APPROVAL OF EMPLOYEE HEALTH CARE INSURANCE PLANS

"Covered Services

"SEC. 1841. (a) (1) To be approved under this title, an employee health care insurance plan must provide, subject to the succeeding provisions of this section, for payment for the following items and services, for each covered individual—

"(A) inpatient hospital services;

"(B) physicians' services;

"(C) medical and other health services;

"(D) home health services;

"(E) post-hospital extended care services;

"(F) outpatient drugs and biologicals;

"(G) routine dental services for individuals under the age of 13;

"(H) developmental vision care services, as defined in regulations prescribed by the Secretary, routine eye and vision examinations, and eyeglasses, for individuals under the age of 13; and

"(I) hearing aids and examinations therefor, for individuals under the age of 13.

The items and services described in the preceding sentence include, but are not limited to, items and services related to mental health care, including alcoholism and drug abuse.

"(2) Notwithstanding the provisions of paragraph (1), the plan must provide that payment will not be made for items and services—

"(A) which are not reasonable and necessary for the diagnosis or treatment of congenital defect, illness, or injury or to improve the functioning of a malformed body member; except for—

"(i) maternity and prenatal items and services, including procedures such as (I) the taking of a prenatal history, (II) a health examination (including the measurement of height and weight, the taking of a blood pressure and such laboratory tests as urine-sugar and albumen, VDRL, and blood typing) and (III) counseling (including counseling respecting nutrition, cigarette smoking, and delivery);

"(ii) normal infant and high-risk infant care for individuals between the time of birth and 1 year of age, including four visists (six visits for high-risk infants) to physicians or physician-supervised assistants for observation and measurement of growth and development (including a complete immunization schedule), and parent counseling (and other measures) to assure necessary followup of abnormalities and with counseling respecting nutrition, hygiene, behavior, and accidents;

"(iii) school entry assessment for individuals of 5 and 6 years of age, including procedures such as (I) review of immunization schedule, (II) growth and systems review, (III) health examination (and subsequent care when determined to be medically necessary), including examination of vision, hearing, speech, teeth, and such laboratory tests as urine culture for females and urine-sugar and albumen, and (IV) parent-child and teacher counseling needed for follow-up and counseling respecting nutrition and accidents;

"(iv) puberty assessment for individuals between the age of 12 and 14 years of age, including procedures such as (I) immunization review and booster, (II) growth and systems review, (III) health examination (and subsequent care when determined to be medically necessary) including examination of skin, teeth, vision, hearing, the taking of a blood pressure, and such laboratory tests as urine culture (for females) and urine-sugar and albumen, and (IV) counseling respecting sex-ual development (including contraception and venereal diseases), nutrition, cigarettes, alcohol, and drugs, accidents, and driver safety;

"(v) adult entry assessment for individuals between the ages of 17 and 19 years of age, including (I) health examination (including the measurement of height and weight, the taking of a blood pressure, examination of vision, hearing, and teeth and such laboratory tests as blood cholesterol, urine-sugar and albumen, culture for gonorrhea (for females), and VDRL), and (II) counseling, including counseling for family planning (including genetic problems), cigarettes, alcohol, and drugs, nutrition, exercise, and accidents;

"(vi) young adult assessment for individuals between the ages of 24 and 26 years of age and for every 5 years until the age of 44, including (I) health examination (including the measurement of height and weight, the taking of a blood pressure, cytologic tests for females and such laboratory tests as blood cholesterol and urine-sugar and albumen), and (II) counseling respecting alcohol and drugs, nutrition, exercise, and sleep;

"(vii) middle-age assessment for individuals 44 to 46 years of age and every 5 years until the age of 59, including (I) health examination (including the measurement of height and weight, the taking of a blood pressure, cytologic examination and breast and mammography examination for females, vision and tonometry, blood-in-stool, rectal, EKG, and laboratory tests for blood cholesterol and blood sugar), and (II) counseling respecting cigarettes, alcohol and drugs, nutrition, exercise, and sleep;

"(viii) older age assessment for individuals 59 to 61 years of age and every 2 years thereafter, including (I) health examination (including the measurement of height and weight, the taking of a blood pressure, mammography and cytologic examination for females, vision and tonometry, hearing, blood-in-stool, rectal, EKG, and such laboratory tests as blood sugar), and (II) counseling respecting nutrition, alcohol and drugs, exercise, sleep, and retirement plans.

"(B) which are eyeglasses or eye examinations therefor, or hearing aids or examinations therefor, except for children under the age of 13;

"(C) for which the individual furnished such items or services has no legal obligation to pay and which no other person (by reason of such individuals membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(D) which are not provided within the United States, except for emergency inpatient hospital and physicians' services;

"(E) which constitute personal comfort items;

"(F) which are orthopedic shoes or other supportive devices for the feet, except for individuals under the age of 6;

"(G) which are custodial care;

"(H) which are cosmetic surgery or provided in connection therewith, except as required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member;

"(I) which are provided by immediate relatives of the individual or members of his household;

"(J) which are—

"(I) the treatment of weak, strained, or flat foot conditions and the prescription of supporting or corrective devices therefor, except when provided to individuals under the age of 6,

"(II) routine foot care; and

"(K) kidney dialysis or transplantation items and services, unless provided by a kidney dialysis or transplanation center or facility which meets such requirements as the Secretary may by regulation provide; or

"(L) to the extent that payment has been made, or can reasonably be expected to be made, with respect to those items and services, under a workmen's compensation law or plan of the United States or a State.

"Coverage Limits

"(b) To be approved under this title, an employee health care insurance plan may not impose any limits with respect to the items and services for which payment must be provided under subsection (a), except that payment for—

"(1) post-hospital extended care services shall be limited to 100 days per calendar year;

"(2) home health services must be limited to 100 visits per calendar year;

"(3) inpatient hospital services for the treatment of mental illness shall be limited to 30 days per calendar year, with each day of partial hospitalization, as defined in regulations prescribed by the Secretary, counting as one-half day of inpatient services;

"(4) services provided on an outpatient basis for the treatment of mental illness shall be limited to the amount determined under this subsection per calendar year, and payment for such services other than services provided on an outpatient basis in a comprehensive community care center, as defined in regulations prescribed by the Secretary, shall be limited to one-half of that amount; and

"(5) routine eye and vision examinations, eyeglasses, hearing aids and examinations therefor, family planning and prenatal and postnatal items and services, and well child care shall be subject to such limitations as the Secretary may by regulation provide.

In November of each year, the Secretary shall determine the limit to be imposed under clause (4), for the following calendar year, which limit shall be the estimated cost of 30 outpatient visits to a private practitioner for the treatment of mental illness.

"Deductibles and Coinsurance

"(c) (1) To be approved under this title an employee health care insurance plan must, subject to paragraph (3), impose, with respect to all items and services, other than outpatient drugs and biologicals, blood and blood products, and items and services described in clauses (i) through (viii) of section 1841 (a) (2) (A), a per individual, per calendar year, deductible equal to the deductible base for that calendar year, as determined under section 1825 (b (2), except that no further deductible shall be imposed under this sentence in any calendar year after three members of a covered family satisfy the deductible requirement for that year. The plan must, subject to paragraph (3), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual, per calendar year, deductible equal to one-third of the deductible base for that calendar year, as determined under section 1825(b)(2). The plan must impose, with respect to blood and blood products, such deductible as the Secretary may by regulation provide.

"(2) The plan must impose, subject to paragraph (3), a coinsurance requirement of 25 percent of expenses (other than expenses for items and services described in clauses (i) through (viii) of section 1841(a)(2)(A)) in excess of any applicable deductible.

"(3) The plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductibles and coinsurance imposed under the plan equals 10.5 percent, in the case of employees without any family members under the age of 65, or 15 percent, in the case of employees with one or more family members under the age of 65, of the income class base, as determined under section 1825(b)(5). The plan must provide that any deductible or coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to part B or C will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan have been met.

“Extended Coverage

“(d) To be approved under this title, an employee health care insurance plan must provide that coverage under the plan will continue to be available to a covered employee to whom the plan is offered by an employer pursuant to section 1801 (a), and the members of his family under the age of 65, for 180 days after the employer is no longer required by section 1801 (a) to offer the plan to the employee, at the same premium rate at which coverage under the plan is available to employees of the employer.

“Coverage in the Event of Failure To Pay Premiums

“(e) To be approved under this title, an employee health care insurance plan must provide that coverage under the plan will not be terminated because of the failure to pay for such coverage until such payment is 90 days in arrears and notice has been given to the individuals whose coverage is to be terminated.

“Health Care

“(f) To be approved under this title, an employee health care insurance plan must provide—

“(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

“(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full participating providers for all items and services, and to associate participating providers for outpatient drugs and biologicals, without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that an account will not be regarded as in default unless payment of amounts due under the account, or any other such account established with respect to the covered individual pursuant to the requirements of this title, is 90 days in arrears.

"Other Requirements

"(g) To be approved under this title, an employee health care insurance plan must provide—

"(1) that payment will be made for items and services in accordance with the applicable reimbursement rates and standards, as determined pursuant to section 1861;

"(2) that, except for emergency services, payment will be made for items and services only to individuals and entities certified as participating providers;

"(3) that the provisions of part B of title XI shall apply to payments for items and services under the plan;

"(4) that payment will not be made for items and services in violation of any order of the Secretary pursuant to section 1122;

"(5) that no individual may be covered under more than one health care plan approved under this title or obtained pursuant to part B or C, and that in the event of coverage under more than one plan, payment will be made, or items and services provided, under only one such plan, as determined under regulations prescribed by the Secretary;

"(6) that the portion of the premium for coverage under the plan which represents the cost of providing coverage in excess of $10,000 per individual per calendar year will be the same for all coverage under the plan and any other employee health care insurance plan of the carrier or self-insured employer approved under this title;

"(7) that the rates applicable to coverage under the plan will be the same for all employees of any employer to whom the plan is provided, except that the rate for coverage of employees without any family members under the age of 65 will be 40 percent of the rate for coverage of employees with one or more family members under the age of 65;

"(8) that the access to information obtained in connection with administration of the plan will be controlled in accordance with such requirements as the Secretary may, by regulation, prescribe;

"(9) that any contract cr arrangement with an employer under which the plan is offered to employees of the employer pursuant to section 1801 will have a term of not more than 1 year, and will expire on December 31; and

"(10) that such uniform reporting methods and statistical procedures as the Secretary may require will be utilized in administration of the plan, and the Secretary will be furnished such information derived from the use of such methods and procedures as he may require to carry out the purposes of this title.

"Modification of Requirements

"(h) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to employee health care insurance plans offered to employees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF GROUP PRACTICE PREPAID HEALTH CARE PLANS

"Benefits

"SEC. 1842. (a) To be approved under this title, a group practice prepaid health care plan must provide—

"(1) for the provision, within the geographic area served by the plan, to covered individuals, of at least those items and services described in subsection (a) of section 1841, without regard to the provisions of subsections (c) through (h) of that section (other than any deductible imposed with respect to blood and blood products) and with no lower limitations than those described in subsection (b) of that section, and for payment for the provision of at least those items and services, within that area, when the provision of the items and services is beyond the control of the covered individual;

"(2) for the provision of, or payment for the provision of, at least those items and services, outside the geographic area served by the plan, when it is medically necessary that an item or service be provided to a covered individual before he can return to the geographic area served by the plan, and

"(3) that the plan will be compensated for the provision of, and payment for, those items and services, solely on a predetermined periodic rate basis, except for such copayments by covered individuals as the Secretary may, by regulation, authorize.

"Organizational Requirements

"(b) For a group practice prepaid health care plan to be approved under this title, the organization through which items and services are provided to covered individuals within the geographic area served by the plan must—

"(1) provide physicians' services (other than infrequently used services, as determined under regulations prescribed by the Secretary) through physicians who are employees or partners of the organization, or through arrangements with one or more groups of physicians engaged in the coordinated practice of their profession for the organization; and

"(2) meet such requirements concerning its organizational structure and financial arrangements as the

Secretary may, by regulation, prescribe for the purpose of assuring that—

"(A) the organization bears the responsibility for the efficient and effective utilization of health care resources to meet the health care needs of covered individuals,

"(B) the individuals, groups, and institutions within the organization or cooperating with it in the provision of health care services to covered individuals share in that responsibility, and

"(C) the organization provides clearly identifiable focal points of responsibility for the performance of all managerial, administrative, and service functions.

"Other Requirements

"(c) To be approved under this title, a group practice prepaid health care plan must provide that—

"(1) coverage under the plan will continue to be available to a covered employee to whom the plan is offered by an employer pursuant to section 1801 (a) and the members of his family under the age of 65 for 180 days after the employer is no longer required by section 1801 (a) to offer the plan to the employee, at the same rate at which coverage under the plan is available to employees of the employer;

"(2) coverage under the plan of employees to whom the plan is offered by an employee pursuant to section 1801 will not be terminated because of the failure to pay for such coverage until payment is 90 days in arrears and notice has been given to the individuals whose coverage is to be terminated;

"(3) the provisions of part B of title XI shall apply to items and services provided under the plan;

"(4) items and services will not be provided in violation of any order of the Secretary pursuant to section 1122;

"(5) no individual may be covered under more than one health care plan approved under this title or obtained pursuant to part B or C, and that in the event of coverage under more than one plan, payment will be made, or items and services provided, under only one such plan, as determined under regulations prescribed by the Secretary;

"(6) the rate applicable to coverage under the plan will be the same for all employees of any employer to whom the plan is provided, except that the rate for coverage of an employee without any family members under the age of 65 will be 40 percent of the rate for coverage of an employee with one or more family members under the age of 65;

"(7) any contract or arrangement with an employer under which the plan is offered to employees of the employer pursuant to section 1801 will have a term of not more than 1 year, and will expire on December 31; and

"(8) such uniform reporting methods and statistical procedures as the Secretary may require will be utilized in administration of the plan, and the Secretary will be furnished such information derived from the use of such methods and procedures as he may require to carry out the purposes of this title.

"Modification of Requirements

"(d) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to group practice prepaid health care plans offered to employees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF INDIVIDUAL PRACTICE PREPAID HEALTH CARE PLANS

"Requirements for Approval

"Sec. 1843. (a) For an individual practice prepaid health care plan to be approved under this title—

"(1) the plan must meet the requirements imposed by section 1842 (a) through (c) with respect to group practice prepaid health care plans, other than the requirements imposed by section 1842 (b) (1) ; and

"(2) the organization through which items and services are provided to covered individuals within the geographic area served by the plan must provide physicians' services (other than infrequently used services, as determined under regulations prescribed by the Secretary) through arrangements with physicians engaged in the practice of their profession on an individual practice basis.

"Modification of Requirements

"(b) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to individual practice prepaid health care plans offered to employees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF SPECIAL EMPLOYEE HEALTH CARE PROGRAMS

"SEC. 1844. For a special employee health care program to be approved under this title—

"(1) the program must provide for the provision, or payment for the provision, to covered individuals, of at least those items and services described in subsection (a) of section 1841;

"(2) so much of the program as provides for payment for the provision of items and services must meet all of the requirements imposed by and pursuant to section 1841 (b) through (h) with respect to employee health care insurance plans approved under this title, except that the program may have lower limitations and deductible and coinsurance requirements than those required by section 1841 (b) and (c);

"(3) so much of the program as provides for the provision of items and services must meet all of the requirements imposed by and pursuant to either section 1843 with respect to group practice prepaid health care plans approved under this title, or section 1844 with respect to individual practice prepaid health care plans approved under this title; and

"(4) the employer must contribute toward the cost of providing coverage under the program to an employee at least as much as he would be required to contribute under section 1802 if the employee elected coverage under a health care insurance plan approved under this title.

"REQUIREMENTS FOR CERTIFICATION OF PROVIDERS

"Full Participating Providers

"SEC. 1845. (a) To be certified as a full participating provider, an individual or entity must—

"(1) agree to accept the payments made by health care insurance plans and special health care programs approved under this title or provided pursuant to part B or C, on the basis of charges against accounts established pursuant to the requirements of section 1841 (f), as the sole means of obtaining payment for so much of the charges for the provision of items and services to individuals covered under those plans and programs as are payable under the plans;

"(2) agree to accept the payments made by health care insurance plans and special health care programs approved under this title or provided pursuant to part B or C, on the basis of valid charges against accounts established pursuant to the requirements of section 1841 (f), as payment in full for the provision of items and services covered, without regard to the deductible and coinsurance requirements described in section 1841 (c), under the plans and programs to individuals covered under the plans and programs, except for any reduction in the amount of any such payment because an account is in default;

"(3) agree not to accept payment for the provision of any item or service from more than one health care insurance plan or special health care program approved under this title or provided pursuant to part B or C; and

"(4) be otherwise eligible, under the provisions of this title, to provide one or more items or services covered under health care insurance plans approved under this title or provided pursuant to part B or C, as determined under regulations prescribed by the Secretary.

"Associate Participating Providers

"(b) (1) To be certified as an associate participating provider, an individual or entity must—

"(A) meet the requirements imposed by clauses (1), (3), and (4) of subsection (a) with respect to full participating providers; and

"(B) agree to accept the payments made by health care insurance plans provided pursuant to part B or C, on the basis of valid charges against accounts established pursuant to the requirements of section 1841(f), as payment in full for the provision of items and services, other than outpatient drugs and biologicals, covered, without regard to the deductible and coinsurance requirements described in section 1841(c), under the plans to individuals covered under the plans, except for any reduction in the amount of any such payment because an account is in default.

"(2) No hospital, skilled nursing facility, or home health agency may be certified as an associate participating provider.

“PART E—ADMINISTRATION AND REGULATION

“APPROVAL OF HEALTH CARE PLANS, CERTIFICATION OF PROVIDERS, ADMINISTRATION OF PLAN REQUIREMENTS, AND REGULATION OF CARRIERS, SELF-INSURED EMPLOYERS, AND PROVIDERS

“SEC. 1861. (a) The Secretary shall certify under this section each State which, by statute or regulation pursuant to statute—

“(1) (A) requires each carrier or self-insured employer which provides an employee health care insurance or prepaid health care plan, and each employer which provides a special health care program, under which coverage is made available pursuant to section 1801 to an employee whose place of employment is within the State, to—

“(I) file the plan or program, or any amendment thereto, with the State not later than 30 days before the plan, program, or amendment becomes effective (or such later date as the Secretary may permit), and

“(II) keep the State currently advised of the employers to whom the plan or program is provided and the employees of such employers to whom coverage under the plan or program is made available;

"(B) provides for prompt review of each such plan, program, or amendment and determination of whether the plan, program, or amendment meets the requirements for approval under this title with respect to employees whose place of employment is within the State, and for prompt notification to the carrier and employers to whom it is known to have provided the plan or amendment, the self-insured employer, or the employer providing the special health care program, of such determination; and

"(C) provides for withdrawal, with respect to employees whose place of employment is within the State, of the approval of any plan, program, or amendment which it determines no longer meets, or is administered in such a manner that it no longer meets, the requirements for approval under this part, and for prompt notification of the carrier and employers to whom it is known to have provided the plan or amendment, the self-insured employer, or the employer providing the special health program, of such determination;

"(2) provides for establishment of the reimbursement rates and standards applicable to payments by health care insurance plans and special health care programs approved under this title or provided pursuant to part B or C for items and services provided within the

State, in accordance with such procedures and criteria as the Secretary may by regulation provide; and for dissemination of the rates and standards to affected carriers, self-insured employers, employers providing special health care programs, certified providers, and covered individuals, in accordance with such procedures as the Secretary may, by regulation, provide;

"(3) (A) provides that any individual, other than an individual who provides health care as an employee of the United States, or any of its agencies or instrumentalities, or entity, other than an entity which is controlled by the United States, or any of its agencies or instrumentalities, wishing to be certified as a full or associate participating provider with respect to items and services provided within the State may file an application for such certification;

"(B) provides for prompt review of each such application and determination of whether the applicant meets the requirements for certification under this title as a full or associate participating provider with respect to items or services provided within the State, and for prompt notification to the applicant of its determination;

"(C) provides for withdrawal of the certification of any individual or entity which it determines no longer meets the requirements for certification under this title with respect to items and services provided within the State, and for prompt notification to the individual or entity of such determination; and

"(D) provides for the dissemination of information concerning the certification of full and associate participating providers to affected carriers, self-insured employers, employers providing special health care plans, and covered individuals, in accordance with such procedures as the Secretary may, by regulation, provide;

"(4) provides for the establishment of arrangements, meeting such requirements as the Secretary may by regulation provide, under which any participating provider may determine the validity of a charge against an account established, pursuant to the requirements of sections 1825(d) and 1841(f), under an employee health care insurance plan or special health care program approved under this title for an employee whose place of employment is within the State, or under an assisted health insurance plan provided within the State pursuant to part B;

"(5) requires each carrier which provides an employee health care insurance plan to an employer with less than 50 employees whose place of employment is within the State under which coverage is made available pursuant to section 1801 to an employee whose place of employment is within the State, to offer the plan to all employers with less than 50 employees whose place of employment is within the State for the purpose of making coverage under the plan available to those employees pursuant to section 1801, and requires that the plan be offered to all such employers under the same rating structure and at the same rates;

"(6) has in effect an agreement with the Secretary under section 1122;

"(7) (A) requires each carrier or self-insured employer which offers or provides, within the State, an employee health care insurance or prepaid health care plan approved under this title, and each employer which offers or provides, within the State, a special employee health care program, to have on file with the State a current statement of the rates, or rating plans and formulas, applicable to the plan or arrangement, containing sufficient specificity to permit determination by the State of whether such rates, or rates based on such plans and formulas, are reasonable in relation to the benefits provided;

"(B) provides for the review of all such rates and rating plans and formulas, and for subsequent disapproval and suspension of any rate determined by the State to be unreasonable in relation to the benefits provided, or any plan or formula as to which it is determined that rates based on such plan or formula are unreasonable in relation to the benefits provided;

"(8) requires that there be an annual fiscal audit of each such carrier and employer by an independent certified public accountant and that the reports of such audits be available to the public;

"(9) requires each carrier which offers or provides, within the State, any plan or arrangement for financing or provision of health care to make available to each individual to whom the plan or arrangement is offered or provided, upon request, written information concerning—

"(A) the benefits and exclusions from coverage under such plan or arrangement,

"(B) the premium rate or rates for such plan or arrangement applicable to such individual, and

"(C) the percentage of the premium rate or rates for such plan or arrangement applicable to such individual which is expected to be paid out as benefits, as determined on the basis of actuarial standards prescribed by the Secretary;

"(10) requires that, except in case of emergency or other exceptional circumstances, each certified provider of health care within the State make available, in accordance with regulations of the Secretary, to individuals covered under a health care insurance plan approved under this title or provided pursuant to part B or C who seek such care directly from the provider, information concerning the provider's charges for commonly provided services, the provider's hours of operation and other matters affecting access to his services, and the extent to which the provider is licensed, accredited, or certified by recognized licensing, accrediting, or certifying agencies or bodies;

"(11) provides for determination of when carriers of employee health care insurance plans are insolvent or impaired and when carriers of prepaid health care plans, and self-insured employers providing employee health care insurance or prepaid health care plans, domiciled in the State, are unable, because of their financial condition, to meet their obligations to covered individuals under such plans; and assures that, in the event a carrier of an employee health care insurance plan is found to be insolvent or impaired, or a carrier of a prepaid health care plan or a self-insured employer providing an employee health care insurance or prepaid health care plan is found to be unable, because of its financial condition, to meet obligations to covered individuals under the plan, under the applicable laws of the State in which the carrier or self-insured employer is domiciled, any valid claim or obligation arising under—

"(A) employee health care insurance or prepaid health care plan coverage provided by the carrier or self-insured employer and made available pursuant to section 1801, to an employee whose place of employment is within the State, or

"(B) in the case of a carrier, a contractual obligation of the carrier to an employer under which employee health care insurance or prepaid health care plan coverage is made available pursuant to section 1801 to such an employee,

will be fully paid, guaranteed, assumed, or reinsured under an insolvency or guarantee fund or other means established or regulated by the State;

"(12) provides for the coordination of benefits under health care insurance plans approved under this title or provided pursuant to part B and other insurance which provides for the financing of health care;

"(13) provides for furnishing the Secretary with such information as he may, by regulation, require concerning the activities carried out by the State under the statutes and regulations required by clauses (1) through (12); and

"(14) provides an opportunity for any aggrieved person to bring a suit in the courts of the State to—

"(A) compel the proper performance of any duty under State law related to the requirements of paragraphs (1) through (12), or to review any decision made pursuant to such a duty, and

"(B) compel any carrier, employer, or certified provider to comply with any requirement related to the requirements of paragraphs (1) through (12).

"(b) Upon his determination, in a calendar year, that a State is entitled to certification under this section, the Secretary shall so notify the State and shall certify it with respect to calendar years beginning after such calendar year.

"INFORMATION FROM EMPLOYERS

"SEC. 1862. The Secretary may require any employer to furnish such information, at such time and in such form, as he finds necessary to determine if part A applies to such employer and, if so, whether such employer is complying with the requirements of that part.

"AGREEMENTS WITH OTHER AGENCIES

"SEC. 1863. The Secretary, pursuant to agreement with the head of any Federal agency, may utilize the services and facilities of such agency in carrying out his functions under this title and may provide for payment therefor in advance or by way of reimbursement, and in such installments, as may be agreed upon.

"JUDICIAL REVIEW OF CERTAIN DETERMINATIONS OF THE SECRETARY

"SEC. 1864. (a) Any State dissatisfied with a determination of the Secretary under section 1861 with respect to whether the State is meeting the requirements of section 1861 may, within 60 days after it has been notified of such determination, file a petition for review of such determination with the United States court of appeals for the circuit in which such State is located. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

"(b) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

"(c) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

"JUDICIAL REMEDIES FOR NONCOMPLIANCE; CRIMINAL SANCTIONS

"SEC. 1868. (a) The Attorney General may bring suit to compel an employer to comply with the provisions of part A. Such a suit shall be brought in the United States district court, including any court enumerated in section 460 of title 28, United States Code, for the district in which the employer's principal place of business is located.

"(b) Any employee may bring suit to compel his employer to comply with the provisions of part A with respect to him and to recover any expenditures necessitated by his employer's failure to do so. Such suit may be brought, without regard to jurisdictional amount, in the United States district court, including any court enumerated in section 460 of title 28, United States Code, for the district in which the plaintiff's place of employment is located or such other district as may be permitted by law.

"(c) (1) Any employer who fails to comply with the requirements imposed upon employers by part A shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000 for each employee with respect to whom he failed to so comply.

"(2) Any person who fails to comply with any regulation or order issued by the Secretary pursuant to section 1862, or who submits false information to the Secretary in connection with any such order or regulation, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000.

"PART F—MISCELLANEOUS PROVISIONS

"DEFINITIONS

"SEC. 1881. For purposes of this title—

"Inpatient Hospital Services

"(a) The term 'inpatient hospital services' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board;

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by other under such arrangements;

excluding, however—

"(4) medical or surgical services provided by a physician who is not an employee of the hospital; and

"(5) the services of a private-duty nurse or other private-duty attendant.

"Hospital

"(b) The term 'hospital' means, except with respect to emergency services provided outside the United States, an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) maintains clinical records on all patients;

"(3) has bylaws in effect with respect to its staff or physicians;

"(4) has a requirement that every patient must be under the care of a physician;

"(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

"(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

"(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

"(8) meets such other requirements as the Secretary finds necessary in the interest of the health safety of the individuals who are furnished services in the institution.

Notwithstanding the preceding provisions of this subsection, such term shall not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a psychiatric hospital (as defined in subsection (c)) or unless it is a tuberculosis hospital (as defined in subsection (d)). The term 'hospital' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

"Psychiatric Hospital

"(c) The term 'psychiatric hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'psychiatric hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Tuberculosis Hospital

"(d) The term 'tuberculosis hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Physicians' Services

"(e) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls.

"Physician

"(f) The term 'physician' when used in connection with the performance of any function or action, means, except with respect to emergency services provided outside the United States, (1) a doctor of medicine or osteopathy, other than an intern, resident, or fellow, legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101 (a) (7)), (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, (3) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses, or (4) except for the purposes of subsections (j), (k), (m), and (n), a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform in the State in which he performs them.

"(g) The term 'medical and other health services' means any of the following items or services—

"(1) physicians' services;

"(2) (A) services, other than physician extender services, and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

"(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) other than physician extender services, incident to physicians' services rendered to outpatients;

"(C) diagnostic services which are—

"(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

"(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

"(D) outpatient physical therapy services; and

"(E) physician extender services;

"(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

"(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

"(5) surgical dressings, and splints, casts, and other devices used for a reduction of fractures and dislocations;

"(6) durable medical equipment, including dialysis equipment and supplies, iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (b) (1) or (j) (1) of this section), whether furnished on a rental basis or purchased;

"(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

"(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; and

"(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (3) unless such laboratory—

"(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality, responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

"(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2) (C) any item or service (except services referred to in paragraph (1)) which—

"(12) would not be included under subsection (a) if it were furnished to an inpatient of a hospital; or

"(13) is furnished under arrangements referred to in such paragraph (2) (C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

"Extended Care Services

"(h) The term 'extended care services' means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

"(1) nursing care provided by or under the supervision of a registered professional nurse;

"(2) bed and board in connection with the furnishing of such nursing care;

"(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

"(4) medical social services;

"(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility as are ordinarily furnished by such facility for the care and treatment of inpatients;

"(6) medical services provided by an intern, resident-in-training, or fellow of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

"(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities;

excluding however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

"Post-Hospital Extended Care Services

"(i) The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer, and for so long as he remains in the skilled nursing facility providing the services and is not discharged from it. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility—

"(A) within 14 days after discharge from such hospital, or

"(B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or

"(C) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital.

An individual shall be deemed not to have been discharged from a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

"Skilled Nursing Facility

"(j) The term 'skilled nursing facility' means an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more certified hospitals and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

"(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

"(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

"(5) maintains clinical records on all patients;

"(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

"(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"(8) has in effect a utilization review plan which meets the requirements of subsection (k);

"(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

"(10) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

"(11) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that, for such periods as are appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home may be waived, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities; and

"(12) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary, except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution.

The term 'skilled nursing facility' also includes a Christian Science Sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such an institution to inpatients.

"To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

"(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

"(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

"(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

"Utilization Review

"(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

"(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

"Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

"(1) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect, if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which has attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

"Home Health Services

"(m) The term 'home health services' means the following items and services furnished to an individual, confined to his home (except when receiving items and services referred to in clause (7)) and in need of skilled nursing care on an intermittent basis, or physical or speech therapy, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital; and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

"(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transporation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

"Home Health Agency

"(n) The term 'home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

"(5) meets such other conditions as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

"(6) meets such other standards and requirements as the Secretary may by regulation provide.

"Outpatient Physical Therapy Services

"(o) The term 'outpatient physical therapy services' means physical therapy services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

"(1) who is under the care of a physician, and

"(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician (as so defined);

excluding, however—

"(3) any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital; and

"(4) any such service—

"(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

"(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

"(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

"(iii) maintains clinical records on all patients,

"(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

"(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

"(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or skilled nursing facility. The term 'outpatient physical therapy services' also includes speech pathology services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

"Drugs and Biologicals

"(p) The term 'drugs' and the term 'biologicals', except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are required by section 503(b) of the Federal Food, Drug, and Cosmetic Act to be dispensed only upon prescription, and such other drugs and biologicals as the Secretary may by regulation provide.

"Outpatient Drugs and Biologicals

"(q) The term 'outpatient drugs and biologicals' means drugs and biologicals required by section 503 (b) of the Federal Food, Drug, and Cosmetic Act to be dispensed only upon prescription and such other lifesaving and sustaining drugs and biologicals as the Secretary may by regulation provide, provided for an individual who is not an inpatient in a hospital or skilled nursing facility.

"Routine Dental Services

"(r) The term 'routine dental services' means services in connection with the examination, care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth provided by a dentist or an assistant to a dentist working under his supervision, except that it does not include orthodontic services.

"Dentist

"(s) The term 'dentist', when used in connection with the performance of any function, means a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function.

"Eyeglasses

"(t) The term 'eyeglasses' means lenses for the correction of a vision defect, other than contact lenses, provided on the basis of an eye examination.

"Eye and Vision Examination

"(u) The term 'eye and vision examination' means an examination for the purpose of determining the need for eyeglasses or vision care, or prescribing, fitting, or changing eyeglasses, performed by an individual who may legally perform such examination in the State in which it is performed.

"Hearing Aids and Examinations

"(v) The term 'hearing aids and examinations' means devices for the correction of hearing defects and examinations for the purpose of determining the need for such a device, subject to such limitations and restrictions as the Secretary may by regulation provide.

"Physician Extender Services

"(w) The term 'physician extender services' means services performed under the supervision and control of a physician by a physician's assistant, nurse practitioner, or other individual, whether or not performed in the office of such physician or at a place at which he is present, if—

"(1) the services are related to the practice by the supervising physician of general medicine, family medicine, internal medicine, geriatrics, or such other medical specialties as the Secretary may by regulation prescribe,

"(2) the individual has—

"(A) successfully completed an appropriate training program approved by the Secretary or by an accrediting organization approved by the Secretary, or

"(B) passed a physician extender certification examination conducted by a certifying organization approved by the Secretary which does not have as a prerequisite graduation from an accredited training program, or

"(C) met such other proficiency requirements as the Secretary may by regulation prescribe,

"(3) the individual may legally perform the services in the State in which the services are performed,

"(4) under the law of the State in which the services are performed, the individual acts, in performing the services, as the agent or otherwise on behalf of the supervising physician or organization which employs the individual, and

"(5) the charges for such services are included in the bills of the supervising physician or the employing organization.

"Carrier

"(x) The term 'carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization which is engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, other than a self-insured employer.

"Self-Insured Employer

"(y) The term 'self-insured employer' means an employer who (either through outside administrators or otherwise) engages, without arrangements with a carrier, in providing, paying for, or reimbursing the cost of, health services for his employees.

"Family

"(z) (1) The term 'employee and the members of his family' means the employee and

"(A) his spouse, and

"(B) each parent, step-parent, unmarried child, and unmarried stepchild of the employee or the employee's spouse receiving more than one-half of his support from the employee and his spouse, who is residing at the place of residence maintained by the employee as his home.

"(2) The term 'members of a family' means an individual and

"(A) his spouse, and

"(B) each parent, step-parent, unmarried child, and unmarried stepchild of the individual or the employee's spouse receiving more than one-half of his support from the individual and his spouse,

who is residing at the place of residence maintained by the individual as his home. For purposes of the preceding sentence, the term 'individual' does not include any individual who is receiving more than one-half of his support from a child and his spouse or a stepchild and his spouse, and is residing at the place of residence maintained by that child or stepchild as his home, or any unmarried individual who is receiving more than one-half of his support from a parent and his spouse, or a step-parent and his spouse, and is residing at the place of residence maintained by that parent or step-parent as his home.

"(3) An individual who is determined, under regulations prescribed by the Secretary, to be temporarily absent from a place of residence for the purpose of engaging in or seeking employment or self-employment (including military service), or attending a school, college, or university, or a course of vocational or technical training, or receiving institutional care, shall be considered to be residing at that place of residence.

"Income

"(aa) The term 'income' means all income, from whatever source derived, as determined under regulations prescribed by the Secretary, and subject to such restrictions and limitations as he may, by regulation, provide.

"Arrangements for Certain Services

"(bb) The term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agency), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"State and United States

"(cc) The terms 'State' and 'United States' have the meaning given to them by subsections (h) and (i), respectively, of section 210.

"Employee

"(dd) Whether an individual is an employee of another shall be determined at common law. The term includes employees of State and local governments, and their agencies and instrumentalities.

"American employer

"(ee) The term 'American employer' means an employer which is (1) a State or local government or an agency or instrumentality of one of the foregoing, (2) an individual who is a resident of the United States, (3) a partnership, if two-thirds or more of the partners are residents of the United States, (4) a trust, if all of the trustees are residents of the United States, or (5) a corporation organized under the laws of the United States or of any State.

"REPORT

"SEC. 1882. On or before January 15 of the year following the fiscal year in which this section is enacted, and annually thereafter, the Secretary shall prepare a report, and submit it to the President for transmission to the Congress, summarizing the activities conducted in the preceding fiscal year in compliance with the amendments to this Act made by the Comprehensive Health Insurance Act of 1974. The report shall include an appraisal of the adequacy of the program under this title to meet the health care needs of the American people, and shall make such legislative recommendations as the Secretary deems appropriate."

EFFECTIVE DATE

SEC. 102. (a) Except as provided in subsection (b), section 101 of this Act shall be effetcive on January 1, 1976, or, if later, the first day of the first calendar year commencing at least 18 months after the enactment of this Act.

(b) Notwithstanding subsection (a), the provisions of title XVIII of the Social Security Act, as in effect prior to the enactment of this Act, shall remain in effect on and after January 1, 1976, with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act, as amended by this Act, and wages and self-employment income earned in States not certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

TRANSITIONAL PROVISIONS CONCERNING PAYMENTS TO CERTAIN EMPLOYERS

SEC. 103. (a) If the total cash wages paid by an employer to his employees whose place of employment is within a single State, in the first year in which the amendments made by section 101 of this Act are effective with respect to those employees, or in any of the succeeding 4 years, when multiplied by the difference between—

(A) the ratio of (I) the cost to the employer of meeting the employer contribution requirement imposed by part A of title XVIII of the Social Security Act, as amended by this Act with respect to those employees in that year to, (II) the total cash wages paid to those employees; and

(B) the ratio of (I) the cost to the employer of providing health benefits to his employees whose place of employment is in that State in the year preceding the year in which the amendments made by section 101 of this Act are effective with respect to those employees to, (II) the total cash wages paid to those employees in that year,

exceeds 3 percent of the total cash wages paid to those employees in that year, the Secretary shall pay to the employer the following percentages of that excess—

(1) for the first year in which the amendments made by section 101 of this Act are effective with respect to those employees, 75 percent.

(2) for the first succeeding year, 60 percent.

(3) for the second succeeding year, 45 percent;

(4) for the third succeeding year, 30 percent; and

(5) for the fourth succeeding year, 15 percent.

(b) There are authorized to be appropriated such sums as may be necessary for the Secretary to make the payments required by subsection (a).

TRANSITIONAL PROVISIONS CONCERNING EMPLOYER CONTRIBUTIONS

SEC. 104. Notwithstanding the provisions of section 1802 of the Social Security Act, as amended by this Act, the employer contribution requirement imposed under section 1802 with respect to employment in a State shall be 65 percent for 3 years beginning with the date that section 1802 is applicable to employment in that State.

TRANSITIONAL PROVISIONS CONCERNING ELIGIBILITY FOR FEDERAL HEALTH CARE BENEFITS

SEC. 105. (a) Anyone who resides in a State certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act—

(1) has attained the age of 65,

(2) (A) attained that age before or during the calendar year in which section 101 of this Act becomes effective under section 102 (a) of this Act, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5 (l) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after the calendar year before the calendar year in which section 101 of this Act becomes effective under section 102 (a) of this Act and before the year in which he attained that age,

(3) is not, and upon filing the appropriate application would not be, entitled to Federal health care benefits under section 1831 of that Act, and is not certifiable

as a qualified railroad retirement beneficiary under section 21 of the Railroad Retirement Act of 1937,

(4) is a resident of the United States (as defined in section 210 (i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall (subject to the limitations of this section) be deemed, solely for purposes of section 1831 of the Social Security Act, to be entitled to monthly insurance benefits under section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes, or upon filing the appropriate application under title II of that Act would become, entitled to Federal health care benefits under section 1831 or become certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of that month shall be deemed to have met those requirements in that month if he files the application before the end of the twelfth month following that month. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) The provisions of subsection (a) shall not apply to any individual who—

(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 210(a)(17) of the Social Security Act, or

(2) has, prior to the beginning of that first month, been convicted of any offense listed in section 202(u) of the Social Security Act.

(c) There is authorized to be appropriated to the Federal Health Care Benefits Trust Fund (established by section 1835 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments, other than payments described in section 1836(l) of the Social Security Act, as amended by this Act, made or to be made during such fiscal year from that Trust Fund with respect to individuals who

are entitled to federal health care benefits under section 1831 solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result from the making of those payments,

(3) any loss in interest to the Trust Fund resulting from the making of those payments,

in order to place that Trust Fund, at the end of the fiscal year, in the same position in which it would have been if the preceding subsections of this section had not been enacted.

TITLE II—REDUCTION IN SERVICES PROVIDED UNDER MEDICAL ASSISTANCE PROGRAMS

AMENDMENTS TO MEDICAID PROGRAM

SEC. 201. (a) Section 1902 (a) of that Act is amended by—

(1) striking out the parenthetical phrase in paragraph (9);

(2) striking out "paragraph (4), (14), or (16)" in paragraph (10) and inserting "paragraph (1), (4) or (5)" in lieu thereof;

(3) striking out clause (II) in paragraph (10), inserting "and" at the end of clause (I), and redesignating clause (III) as clause (II);

(4) striking out paragraph (13) and inserting the following new paragraph in lieu thereof:

"(13) provide—

"(A) for inclusion of at least the services listed in clauses (1) and (2) of section 1905(a), and

"(B) for payment for the items and services provided under the plan on the basis of such standards as the Secretary may be regulation prescribe;";

(5) striking out "through (5) and (7)" in paragraph (14)(A) and inserting "and (2)" in lieu thereof;

(6) striking out paragraph (15);

(7) striking out "(including drugs)" and "community pharmacy," in paragraph (23);

(8) inserting "psychiatric" before "hospitals" in paragraph (24);

(9) striking out "1861(j)" in paragraph (28) and inserting "1881(j)" in lieu thereof; and

(10) striking out "the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not" and ", the State agency responsible for such licensing," in paragraph (33)(B).

(b) Section 1903(a) of such Act is amended by—

(1) striking out everything after "under the State plan" in clause (1) and inserting "; plus" in lieu thereof; and

(2) striking out clause (5).

(c) Section 1903(b) of such Act is amended by striking out paragraph (1).

(d) Section 1903(g)(1) of such Act is amended by striking out "hospital (including an institution for tuberculosis)," and "inpatient hospital services (including tuberculosis hospitals)," in the matter before clause (A); and striking out "section 1812" and inserting "title XVIII" in lieu thereof.

(e) Section 1903(i) of such Act is amended by striking out clauses (1) through (3).

(f) Section 1903(i) of such Act is further amended by—

(1) striking out "hospital or" each time that it appears in clause (4); and

(2) striking out "1861(k)" each time that it appears in clause (4) and inserting "1881(k)" in lieu thereof.

(g) Section 1903 is further amended by striking out subsections (j) and (k).

(h) The first sentence of section 1905(a) of such Act is amended by striking out everything after "all of such cost-" and inserting in lieu thereof the following:

"(1) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older;

"(2) home health care services;

"(3) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

"(4) for individuals 65 years of age or older, inpatient hospital services in an institution for mental diseases, and skilled nursing services and intermediate care facility services in an institution for tuberculosis or mental diseases;

"(5) inpatient psychiatric hospital services for individuals under 21, as defined in subsection (h); and

"(6) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary which is provided to an individual in an institution or is intended to reduce the need for institutionalization;

except that such term does not include—

"(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution);

"(B) except as otherwise provided in paragraph (5), any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases; or

"(C) any such payments with respect to care or services which must be covered under a health care insurance plan provided under part B or C of title XVIII or for any premium, deductible, or coinsurance which must be imposed under such plan."

(i) Section 1905 of such Act is further amended by—

(1) striking out subsections (e) and (g); and

(2) striking out everything after "Indian reservation" in subsection (i) and inserting "and is certified under title XVIII." in lieu thereof.

(j) Section 1910 of such Act is amended to read as follows:

"Sec. 1910. An institution certified as a skilled nursing facility under title XVIII shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902 (a) (28)."

(k) Section 1902 (b) is amended by inserting "submitted by a State certified under section 1861" after "approve any plan".

EFFECTIVE DATE

SEC. 202. The amendments made by section 201 shall be effective with respect to payments under section 1903 of the Social Security Act for quarters beginning on or after the effective date of section 101 of this Act under section 102 (a) of this Act.

AMENDMENTS TO PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 301. (a) (1) Section 1151 of the Social Security Act is amended by—

(A) inserting ", or which are provided," immediately after " (in whole or in part) ",

(B) inserting ", or which are provided," immediately before "under the Social Security Act", and

(C) inserting ", and such services will be provided" immediately after "payment for such services will be made".

(2) Section 1155 (a) (1) of that Act is amended by—

(A) striking out " (subject to the provisions of subsection (g)) ", and

(B) striking out "under this Act" and inserting "under title V or XIX, for which payment may be made by a health care insurance plan or special employee health care program approved under title XVIII or provided pursuant to part B or C of that title, or which are provided by a prepaid health care plan or special employee health care program approved under title XVIII," in lieu thereof.

(3) Section 1155 of that Act is further amended by striking out subsection (g).

(4) Section 1157 of that Act is amended by striking out the last sentence therein.

(5) Section 1158 (a) of that Act is amended by striking out everything before clause (1) and inserting "Except as provided for in section 1159, no Federal funds appropriated under title XIX for the provision of health care items and services shall be used (directly or indirectly) for the payment for, and no health care insurance plan or special employee health care program approved under title XVIII or provided under part B or C of that title shall make payment on, any claim for the provision of any item or service, unless the Secretary pursuant to regulation determines that the claimant is without fault if—" in lieu thereof.

(6) Section 1159 (a) of that Act is amended by striking out everything before "or a provider or practitioner" and inserting "Any individual entitled to benefits under title XIX or covered under a health care insurance plan or special employee health care program approved under title XVIII or provided under part B or C of that title" in lieu thereof.

(7) Section 1160(a) of that Act is amended by striking out "to beneficiaries and recipients under this Act" and inserting "to individuals eligible for benefits under title V or XIX or covered under a health care insurance plan, prepaid health care plan, or special employee health care program approved under title XVIII or provided under part B or C of that title" in lieu thereof.

(8) Section 1160(b) of that Act is amended by striking out "under this Act" and inserting "under title V or XIX, or by a health care insurance plan or special employee health care program approved under title XVIII or provided pursuant to part B or C of that title" in lieu thereof.

(9) Section 1160 of that Act is further amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) If after reasonable notice and opportunity, for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendation to the Secretary pursuant to section 1157 (which report and recommendation shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility on behalf of a prepaid health care plan or special employer health care program approved under title XVIII has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may require the prepaid health care plan or special employee health care program to take such remedial action as he determines is appropriate, including, but not limited to, professional education, or suspension or termination of personnel.".

(b) The amendments made by this section shall be effective with respect to items and services provided in States certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

AMENDMENTS TO CAPITAL EXPENDITURES REVIEW PROGRAM

Sec. 302. (a) Section 1122 (a) of the Social Security Act is amended by striking out so much of such section as precedes "are not used" and inserting "The purpose of this section is to assure that Federal funds paid pursuant to titles V and XIX, payments made under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title, and payments made to prepaid health care plans and special employee health care programs approved under title XVIII" in lieu thereof.

(b) Section 1122 is further amended by striking out subsection (c).

(c) Section 1122 is further amended by striking out so much of subsection (d) as follows clause (B) of paragraph (1), and subsection (e), and inserting in lieu thereof the following: "then he shall, in determining the Federal payments to be made under title V or XIX, exclude amounts with respect to services furnished, during such period as the Secretary finds necessary in any case to effectuate the purpose of this section, in the health care facility for which such capital expenditure is made; shall notify carriers, self-insured employers, and employers which provide coverage under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title to individuals who in the judgment of the Secretary could reasonably be expected to seek services in the facility, that payments are not to be made with respect to services furnished in the facility to such individuals during such period, and direct such carriers, self-insured employers, and employers to notify such individuals of such exclusion; and shall notify carriers, self-insured employers, and employers which provide coverage under prepaid health care plans and special employee health care programs approved under title XVIII which in the judgment of the Secretary could reasonably be expected to provide services in the facility, that items and services are not to be provided under the plan in the facility during such period.

"(2) With respect to any organization which is reimbursed primarily on a per capita basis, the Secretary shall determine, for purposes of Federal payments under titles V and XIX, the amount which in his judgment is a reasonable equivalent of the amount which would be excluded under this subsection if payment were made on some other basis.

"(3) The period referred to in paragraph (1) for which the exclusion of payment for, and provision of, services applies shall begin with respect to services provided after—

"(A) in the case of title V or XIX, the Secretary notifies the State or other recipient of Federal funds thereunder of his determination;

"(B) in the case of payments under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title, notice to those individuals covered under such plans who, in the judgment of the Secretary, could reasonably be expected to seek services in the facility involved; and

"(C) in the case of services provided under prepaid health care plans and special employee health care insurance programs approved under title XVIII, notice to the carriers, self-insured employers, and employers which provide coverage under those plans which, in the judgment of the Secretary, could reasonably be expected to provide services in the facility.

"(4) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion under paragraph (1) of payments for, and provision of, services furnished in any health care facility would discourage the operation or expansion of such facility (or in the case of a facility of a health maintenance organization, the operation or expansion of such organization) and such facility or organization has demonstrated to his satisfaction that it is capable of providing comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective administration of title V, XVIII, or XIX, he shall not exclude such payments pursuant to paragraph (1) or notify carriers, self-insured employers, or employers not to make such payments or provide such services.

"(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (c) if the person had acquired it by purchase, the Secretary shall provide for such an exclusion with respect to services furnished in such facility by such person."

(d) The amendments made by this section shall be effective with respect to capital expenditures in States certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

MISCELLANEOUS SOCIAL SECURITY AMENDMENTS

SEC. 303. (a) (1) Section 201 (g) (1) of the Social Security Act is amended by—

(A) inserting ", the Federal Health Care Benefits Trust Fund," immediately after "Federal Hospital Insurance Trust Fund",

(B) striking out "with respect to title XVI" and inserting "with respect to titles XVI and XVIII" in lieu thereof, and

(C) striking out "section 1601" and inserting "sections 1601 and 1836" in lieu thereof.

(2) Section 201 (i) of that Act is amended by inserting "the Federal Health Care Benefits Trust Fund," immediately after "Federal Hospital Insurance Trust Fund,".

(b) (1) Section 218 (e) of that Act is amended by—

(A) striking out "3101 and 3111" in paragraph (1) (A) and inserting "3101 (a) and 3111 (a), and in the case of a State not certified under section 1861, 3101 (b) and 3111 (b), respectively, in lieu thereof, and

(B) striking out "3111" in paragraph (2) (B) and inserting "3111 (a), and in the case of a State not certified under section 1861, 3111 (b)," in lieu thereof.

(2) Section 218 (f) (3) of that Act is amended by striking out "3101 and 3111" and inserting "3101 (a) and 3111 (a), and in the case of a State not certified under section 1861, 3101 (b) and 3111 (b),", respectively, in lieu thereof.

(3) Agreements under section 218 of the Social Security Act in effect on the effective date of the amendments made by this subsection shall be deemed to be modified to the extent necessary to meet the requirements of section 218, as amended by this subsection.

(c) Subsections (a) and (b) of section 226 of the Social Security Act are each amended by inserting "residing in a State which is not certified under section 1861" immediately after "Every individual".

(d) Section 505 (a) (6) of such Act is amended by striking out "which would be determined under section 1861 (v) as the reasonable cost of such services for purposes of title XVIII" and inserting "determined in accordance with methods and standards as the Secretary may, by regulation, provide" in lieu thereof.

(e) Section 1116 of such Act is amended by—

(1) inserting "or part B of title XVIII," after "part A of title IV," each time that it appears therein; and

(2) inserting "1824," after "1604,".

(f) (1) Section 202 (u) of that Act is amended by striking out "insurance benefits under part A of" and inserting "Federal benefits under" in lieu thereof.

(2) Section 202 (v) of that Act is amended by striking out "part A" each time that it appears therein and inserting "the Federal programs" in lieu thereof.

(g) The amendments made by this section shall be effective on the effective date of section 101 of this Act under section 102 (a) of this Act.

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 304. (a) The matter before clause (1) in section 322 (a) of the Public Health Service Act is amended by—

(1) striking out "without charge", and

(2) inserting ", subject to such charges as the Secretary may by regulation impose" immediately after "stations of the Service".

(b) Section 1310 (a) of the Public Health Service Act is amended by inserting "whose place of employment is not within a State certified under section 1861 of the Social Security Act" immediately after "offered to its employees".

(c) The amendments made by this section shall be effective on the effective date of section 101 of this Act under section 102 (a) of this Act.

AMENDMENTS TO THE RAILROAD RETIREMENT PROGRAM

SEC. 305. (a) Section 5 (k) of the Railroad Retirement Act of 1937 is amended by inserting "or Federal Health Care Benefits Trust Fund, as applicable" immediately after "Federal Hospital Insurance Trust Fund".

(b) (1) Section 21 (a) of that Act is amended by striking out everything after "individuals described in subsection (b) of this section to" and inserting "Federal health care benefits under section 1831 of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section with respect to individuals to whom such section applies. For purposes of section 11, a determination with respect to the rights of an individual under this section shall be considered to be a decision with respect to an annuity."

(2) Section 21 (c) of that Act is amended by striking out "part A" and inserting "part C" in lieu thereof.

(3) Section 21 (d) of that Act and section 105 of the Social Security Amendments of 1965 are each amended by striking out the parenthetical phrase therein.

(4) Section 21 (e) of the Railroad Retirement Act of 1937 is amended to read as follows:

"(e) Individuals described in subsection (b) of this section shall have the same rights to Federal health care benefits with respect to health care provided in Canada as individuals to whom section 1831 of the Social Security Act applies have with respect to health care provided in the United States, and this subsection shall be administered by the Board as if the provisions of part C of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health, Education, and Welfare were to the Board, as if references to the Federal Health Care Benefits Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included Canada or a subdivision thereof, and as if title XVIII of the Social Security Act contained such modifications in its requirements and provisions as the Board determines are appropriate with respect to health care provided in Canada. The payments herein provided for shall be made from the Railroad Retirement Account in accordance with, and subject to, the conditions applicable under section 10 (b) in making payment of other benefits, but only to the extent that the amount of payments hereunder provided for exceeds the amount payable pursuant to the law in effect in Canada.".

(c) Section 22 of that Act is repealed.

(d) (1) The amendments made by subsection (a) shall be effective on the effective date of section 101 of this Act under section 102 (a) of this Act.

(2) The amendments made by subsections (b) and (c) shall be effective with respect to individuals residing in States certified under section 1861 of the Social Security Act, as amended by this Act.

AMENDMENTS TO THE INTERNAL REVENUE CODE

SEC. 306. Effective with respect to wages in States certified under section 1861 of the Social Security Act, as amended by this Act paragraphs (5), (6) (A), (6) (B), (6) (C), and (7) of section 3121 (b) of that Code are each amended by inserting "with respect to the taxes imposed by sections 3101 (a) and 3111 (a)," immediately before "service" the first time that it appears in each of those paragraphs.

TITLE IV—GENERAL PROVISIONS

GENERAL SEVERABILITY

SEC. 401. If a provision enacted by this Act is held invalid, all other provisions so enacted shall remain in effect. If a provision enacted by this Act is held invalid in one or more of its applications, the provision shall remain in effect with respect to all other applications.

DEFINITION

SEC. 402. As used in this Act and in the amendments made by this Act, the term "Secretary" means, unless the context otherwise requires, the Secretary of Health, Education, and Welfare.

94TH CONGRESS
1ST SESSION

H. R. 5990

IN THE HOUSE OF REPRESENTATIVES

APRIL 15, 1975

Mr. BURLESON of Texas (for himself, Mr. DUNCAN of Tennessee, Mr. NIX, Mr. QUILLEN, Mr. THONE, Mr. ROBERTS, and Mr. WON PAT) introduced the following bill; which was referred to the Committees on Interstate and Foreign Commerce and Ways and Means

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A BILL

To amend the Internal Revenue Code of 1954 and the Social Security Act to provide a comprehensive program of health care by strengthening the organization and delivery of health care nationwide and by making comprehensive health care insurance (including coverage for medical catastrophes) available to all Americans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "National Health Care Act of 1975".

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TITLE V—PROVISIONS TO MAKE COMPREHENSIVE HEALTH CARE INSURANCE AVAILABLE TO ALL

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Sec. 537. Effective date.

TITLE I—FINDINGS AND DECLARATION OF PURPOSE

SEC. 101. FINDINGS.

The Congress hereby finds that—

(a) America confronts a critical testing of its capacity to meet for all of its citizens one of the most basic of human needs, that of protecting and maintaining personal health;

(b) Every citizen of the United States of America should have access to quality health care, but too many Americans find it difficult to secure quality health care when they need it, where they need it, at prices they can afford;

(c) The Nation needs systems of health care organizations, delivery, and financing which combine the high scientific and technical competence of the medical and allied health professions; the flexibility, innovativeness, efficiency, and managerial skills of private enterprise; the legislative and fiscal capacities of government at all levels; and the potentialities of consumer and community participation in developing and maintaining such systems of health care.

SEC. 102. DECLARATION OF PURPOSE.

The Congress declares the purpose of the Act to be to improve the organization, delivery, and financing of health care for all citizens of the United States of America by increasing health personnel, promoting ambulatory care, strengthening health planning, establishing national standards of health care benefits including coverage for medical catastrophes, encouraging provision of such benefits through comprehensive health care insurance, and by assisting persons of low income or in poor health to secure that insurance.

TITLE II—PROVISIONS TO INCREASE THE SUPPLY AND IMPROVE THE DISTRIBUTION OF HEALTH CARE PERSONNEL

SEC. 201. STUDENT LOANS FOR TRAINING IN THE HEALTH PROFESSIONS AND NURSING.

(a) Student Loans for Training in the Health Professions.—Subsection (a) of section 741 of the Public Health Service Act is amended to read as follows:

"(a) In the case of any student, the total of the loans from a loan fund established under this subpart for any academic year (or its equivalent, as determined under regulations of the Secretary) may not exceed the lesser of $5,000 or the sum of—

"(1) the actual cost of tuition and fees, and

"(2) the reasonable expenditures (as determined in accordance with regulations) for supplies, books, room and board, and other related costs.

In the granting of such loans, a school shall give preference to persons who enter as first-year students after June 30, 1975.".

(b) AUTHORIZATION OF APPROPRIATIONS.—Effective with respect to fiscal years beginning after June 30, 1975, subsection (a) of section 742 of such Act is amended—

(1) by inserting the following before the period at the end of the first sentence: ", $62,500,000 for the fiscal year ending September 30, 1976, and $50,000,000 for the fiscal year ending September 30, 1977";

(2) by striking out "June 30, 1975" in the second sentence and inserting in lieu thereof "September 30, 1978"; and

(3) by striking out "July 1, 1974" in the second sentence and inserting in lieu thereof "October 1, 1977".

(c) CONFORMING AMENDMENT.—Section 743 of such Act is amended by striking out "1977" wherever it appears therein and inserting in lieu thereof "1980".

(d) AUTHORIZATION OF APPROPRIATIONS.—The first sentence of section 824 of such Act is amended by striking all of "1974" the first time it appears and by inserting in lieu thereof the following: "$40,000,000 for the fiscal year ending June 30, 1975, $50,000,000 for the fiscal year ending September 30, 1976, and $40,000,000 for the fiscal year ending September 30, 1977, and such sums for the fiscal year ending September 30, 1978, and each of the 2 succeeding fiscal years as may be necessary to enable students who have received a loan for any academic year ending before October 1, 1977, to continue or complete their education."

(e) CONFORMING AMENDMENT.—Section 826 of such Act is amended by striking out "1977" wherever it appears therein and inserting in lieu thereof "1980".

SEC. 202. SCHOLARSHIP GRANTS AND STUDENT LOANS FOR TRAINING IN THE ALLIED HEALTH PROFESSIONS.

(a) RECOMMENDATIONS OF HEALTH POLICY BOARD.—Subsection (a) of section 794B of the Public Health Service Act is amended by adding the following after the word "prescribe": ", with due regard to any relevant recommendations of the Health Policy Board established pursuant to title IV of the National Health Care Act of 1975".

(b) AUTHORIZATION OF APPROPRIATIONS.—Subsection (f) of such section is amended to read as follows:

"(f) For the purpose of carrying out the provisions of this section there are authorized to be appropriated $12,500,000 for the fiscal year ending September 30, 1976, and $12,000,000 for the fiscal year ending September 30, 1977."

(c) CANCELLATION OF STUDENT LOANS.—Subsection (b) (2) (C) of section 794D of such Act is amended to read as follows:

"(C) not to exceed 50 percent of any such loan (plus interest) shall be canceled for full-time employment as an allied health professional in any public or nonprofit private institution or agency (including comprehensive ambulatory health care centers), at the rate of 20 percent of the amount of such loan plus interest thereon, which was unpaid on the first day of such service, for each complete year of such service, except that such rate shall be 33⅓ percent for each complete year of service as an allied health professional in any area in a State which is determined by the Secretary, upon recommendation by the appropriate State health planning and development agency (designated or established pursuant to section 1521 of title XV of the Public Health Service Act), in accordance with regulations of the Secretary, to be an area which has a shortage of and need for such allied health professionals, and for cancellation at such higher rate, an amount equal to an additional 50 percent of the total amount of such loans plus interest may be canceled;".

(d) AUTHORIZATION OF APPROPRIATIONS FOR LOANS.—Subsection (c) of section 794D of such Act is amended to read as follows:

"(c) There are authorized to be appropriated to the Secretary for Federal capital contributions to the student loan funds pursuant to subsection (a) (2) (B) (i) $18,750,000 for the fiscal year ending September 30, 1976, and $15,000,000 for the fiscal year ending September 30, 1977, and such sums for the fiscal year ending September 30, 1978, and each of the 2 succeeding fiscal years as may be necessary to enable students who have received a loan for any academic year ending before October 1, 1977, to continue or complete their education. Sums appropriated pursuant to this subsection for any fiscal year shall be available to the Secretary (1) for payments into the fund established by subsections (f) (4) and (2) in accordance with agreements under this section for Federal capital contributions to schools with which such agreements have been made, to be used, together with deposits in such funds pursuant to subsection (a) (2) (B) (ii), for establishment and maintenance of student loan funds."

(e) Distribution of Assets From Loan Funds.—

(1) Subsection (e) of section 794D of such Act is amended by striking out "1977" wherever it appears therein and inserting in lieu thereof "1980".

(2) Subsection (f) (1) (A) of section 794D of such Act is amended by striking out the word "two" and inserting in lieu thereof "six".

(3) Subsection (f) (3) of section 794D of such Act is amended by striking out "$35,000,000" and inserting in lieu thereof "$60,000,000".

SEC. 203. TRAINING FOR PERSONNEL NEEDED IN COMPREHENSIVE AMBULATORY HEALTH CARE CENTERS.

(a) Section 795 (1) (A) of the Public Health Service Act is amended—

(1) by inserting "health care center administration," immediately after the first reference to "dental hygiene"; and

(2) by inserting "which shall include the curriculums for various types of allied health professions which the Secretary finds to be necessary for the effective operation of comprehensive ambulatory health care cen-

ters (defined in section 645)," immediately after "regulation,".

(b) Section 795(1)(C) of the Public Health Service Act is amended to read as follows:

"(C) which, if in a college or university which does not include a teaching hospital or a comprehensive ambulatory health care center (defined in section 645) or in a junior college, is affiliated (to the extent and in the manner determined in accordance with regulations) with such a hospital or a comprehensive ambulatory health care center,".

(c) Title VII of the Public Health Service Act is amended by adding the following new part I after section 799A as follows:

"PART I—GRANTS FOR PLANNING AND ESTABLISHMENT OF CURRICULUMS FOR TRAINING COMPREHENSIVE AMBULATORY HEALTH CARE TEAMS

"SEC. 799B. (a) There are authorized to be appropriated $12,500,000 for the fiscal year ending September 30, 1976, and $25,000,000 for the fiscal year ending September 30, 1977, for special project grants under subsection (b) of this section. The portion of the sums so appropriated for each fiscal year which shall be available for grants under such section shall be determined by the Secretary unless otherwise provided in the Act or Acts appropriating such sums for such year.

"Special Project Grants

"(b) Grants may be made, from sums available therefor from appropriations under subsection (a), to assist schools of medicine, training centers for allied health professions (defined in section 795), and other educational institutions—

"(1) to meet the cost of special projects to plan, develop, demonstrate, and evaluate curriculums or establish new programs or modifications of existing programs of education, to train physicians to coordinate teams of health care personnel engaged in providing comprehensive health care on an ambulatory basis; or

"(2) to meet the cost of developing curriculums and training programs for new levels or types of health professions, nurses, and allied health professions needed to staff comprehensive ambulatory health care centers (defined in section 645); or

"(3) to meet the cost of planning experimental teaching facilities or other facilities necessary to initiate, strengthen, improve, or expand programs to train persons to administer and staff such comprehensive ambulatory health care centers.

"Applications for Grants

"(c) (1) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under subsection (b) for any fiscal year must be filed.

"(2) To be eligible for a grant under this part, the applicant must (A) be a public or other nonprofit school of medicine, training center for allied health professions, or other educational institution which includes or is affiliated with a comprehensive ambulatory health care center (defined in section 645), and (B) be accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that the requirement of this clause (B) shall be deemed to be satisfied if in the case of a school which by reason of no, or an insufficient, period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Secretary makes a final determination as to approval of the application.

"(3) The Secretary may approve any application for a grant under this part if he determines, after giving due consideration to any relevant findings or recommendations of the Health Policy Board, that the proposed grant will serve to alleviate the shortage of health care personnel.

"(4) A grant under this part may be made only if the application therefor—

"(A) is approved by the Secretary upon his determination that the applicant meets the eligibility conditions set forth in subsection (c) (2) of this section;

"(B) contains such additional information as the Secretary may require to make the determinations required of him under this part and such assurances as he may find necessary to carry out the purposes of this part; and

"(C) provides for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this part.

"(5) In determining priority of projects, applications for which are filed under subsection (c) (1) of this section, the Secretary shall give consideration to—

"(A) the extent to which the project will increase enrollment of full-time students receiving the training for which grants are authorized under this part;

"(B) the relative need of the applicant for financial assistance;

"(C) the extent to which the project may result in development of curriculum, curriculum improvement, or improved methods of training or will help to reduce the period of required training without adversely affecting the quality thereof; and

"(D) the health care needs of the Nation and the extent to which the proposed project will assist in the alleviation of shortages in health care personnel."

SEC. 204. GRANTS TO PERSONNEL IN THE HEALTH PROFESSIONS, ALLIED HEALTH PROFESSIONS, AND NURSING FOR SERVICE IN AREAS OF CRITICAL NEED.

(a) Authority To Make Grants.—Title VII of the Public Health Service Act is amended by adding after section 799B (as added by this Act) the following new part J as follows:

"Part J—Grants to Personnel in the Health Professions, Allied Health Professions, and Nursing for Service in Areas of Critical Need

"Sec. 799C. (a) There are authorized to be appropriated $37,500,000 for the fiscal year ending September 30, 1976, and $50,000,000 for the fiscal year ending September 30, 1977, for the establishment and operation of a special fund from which the Secretary shall make grants to personnel in the health professions, allied health professions, and nursing for the purpose of alleviating the maldistribution of such health care personnel and improving health care services in areas having a critical need for such personnel.

"Applications for Grants

"(b) (1) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) before which applications for grants under this part for any fiscal year must be filed.

"(2) To be eligible for a grant under this part, the applicant must be (A) a health professional, allied health professional, or nurse, or (B) a person engaged in a course of training who will, at the time the grant is to commence, be a health professional, allied health professional, or nurse.

"(3) Applications for grants from the special fund established by this part may be approved by the Secretary only if—

"(A) the applicant is qualified by education and training to provide a type of health care service determined by the Secretary, upon recommendation of the appropriate State health planning and development agencies, to be needed in areas which have critical health manpower shortages;

"(B) the applicant agrees to perform health care services in an area of a State which has been designated by the Secretary, upon recommendation of the appropriate State health planning and development agency, as having a critical need for such health professional, allied health professional, or nurse; and

"(C) the application contains reasonable assurance that the applicant will provide health care services in an area of critical need for a period of not less than 2 years.

"(4) Any application for a grant filed by a person mentioned in subsection (b) (2) (B) may be approved by the Secretary only on the condition that such applicant shall have met the qualifications of subsection (b) (2) (A) and subsection (b) (3) at or before the time the grant is to commence.

"Grants for Service in Areas of Critical Manpower Shortages

"(c) The Secretary or his designee is authorized to enter into individual contracts with applicants approved pursuant to subsection (b) of this section. Such contracts shall provide for the payment of grants from the special fund established under this part and shall provide for payment to be made quarterly on an annualized basis. Such contracts shall also specify that at the end of each contract year an additional payment shall be made, if necessary, in an amount sufficient to guarantee that the applicant receives, from all payments made under this part with respect to the contract year and all other income derived during the contract year from providing health care services in the area of critical need, a total amount equal to at least 110 percent of the national annual median income for persons of comparable education and training or 110 percent of the applicant's earnings from providing health care services in the previous year, whichever is greater.

"In determining the actual amount of a grant under this part the Secretary or his designee shall take the following factors into account:

"(1) the national median annual income for the applicant's profession, determined in accordance with regulations;

"(2) the cost of living in the area in which the applicant is to serve;

"(3) the background, training, and education of the applicant;

"(4) the amount of income the applicant can reasonably expect to receive from service in the area of critical need;

"(5) the number of persons of the applicant's profession needed in the area of critical need;

"(6) where appropriate, all or part of the reasonable cost of equipment, supplies, and facilities; and

"(7) such other factors as the Secretary deems reasonable."

(b) CONFORMING AMENDMENT.—Section 329 (b) (1) of the Public Health Service Act is amended by inserting after "(A) designate" the phrase ", upon recommendation of the appropriate State health planning and development agency,".

TITLE III—PROVISIONS TO ENCOURAGE COMPREHENSIVE AMBULATORY HEALTH CARE CENTERS

SEC. 301. AMENDMENT OF PURPOSE.

Section 600 (a) of the Public Health Service Act is amended by inserting ", including comprehensive ambulatory health care centers" immediately after "other medical facilities".

SEC. 302. AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION AND MODERNIZATION GRANTS.

Section 601 of the Public Health Service Act is amended by adding after subsection (c) the following new subsection:

"(d) $200,000,000 for the fiscal year ending June 30, 1976, and for each of the next succeeding 4 fiscal years for grants for the construction and modernization of comprehensive ambulatory health care centers, and for those administrative, operating, and maintenance costs during the first 3 years of operation of such centers as may be approved by the Secretary."

SEC. 303. STATE ALLOTMENTS.

Effective with respect to appropriations pursuant to section 601 of the Public Health Service Act for fiscal years beginning after June 30, 1975, section 602 (a) (1) of such Act is amended to read as follows:

"(a) (1) Each State shall be entitled for each fiscal year to an allotment bearing the same ratio to the sums appropriated for such year pursuant to subparagraphs (1), (2), and (3), respectively, of section 601 (a), to an allotment bearing the same ratio to the sums appropriated for such year pursuant to section 601 (b), and to an allotment bearing the same ratio to the sums appropriated for such year pursuant to section 601 (d), as the product of—

"(A) the population of such State, and

"(B) the square of its allotment percentage, bears to the sum of corresponding products for all of the States."

SEC. 304. PRIORITY OF PROJECTS.

Section 603 (a) of the Public Health Service Act is amended by striking "and" after subparagraph (6), by adding "and" after subparagraph (7), and by inserting after subparagraph (7) thereof the following new subparagraph:

"(8) in the case of projects for the construction of comprehensive ambulatory health care centers, to facilities located in densely populated areas where such facilities do not now exist, as determined by the Secretary."

SEC. 305. STATE PLANS.

(a) Section 604(a)(4) of the Public Health Service Act is amended by redesignating subparagraphs (D) and (E) thereof as subparagraphs (E) and (F), respectively, and inserting after subparagraph (C) thereof the following new subparagraph:

"(D) the comprehensive ambulatory health care centers needed to provide adequate ambulatory health care services for patients residing in the State, including many services which traditionally have been rendered in hospitals, and a plan for distribution of such centers throughout the State."

(b) Section 604(a)(5) of the Public Health Service Act is amended by inserting "comprehensive ambulatory health care centers" immediately after "outpatient facilities."

SEC. 306. RECOVERY OF FUNDS.

Section 609(b) of the Public Health Service Act is amended by inserting "comprehensive ambulatory health care center," immediately after "outpatient facility,".

SEC. 307. LOAN GUARANTEES AND LOANS FOR MODERNIZATION AND CONSTRUCTION OF COMPREHENSIVE AMBULATORY HEALTH CARE CENTERS.

Section 621 of the Public Health Service Act is amended by inserting "comprehensive ambulatory health care centers," immediately after "outpatient facilities," in paragraphs (1) and (2) of subsection (a) thereof.

SEC. 308. DEFINITION OF COMPREHENSIVE AMBULATORY HEALTH CARE CENTER.

Section 645 of the Public Health Service Act is amended by adding after paragraph (l) the following new paragraph:

"(m) The term 'comprehensive ambulatory health care center' means a facility (located in or apart from a hospital and whether or not part of a health maintenance organization) which is organized, equipped, and staffed so as to provide to individuals and families, on a coordinated and continuing basis, a broad range of ambulatory health services, and which—

"(1) has a staff of physicians licensed to practice medicine who provide medical and surgical care for patients not requiring hospitalization;

"(2) possesses or has reasonable access to one or more operating rooms and appropriate recovery rooms, adequately equipped and staffed, in accordance with standards promulgated by the Secretary, to perform those surgical procedures which can be safely performed on a nonconfinement basis;

"(3) is equipped to provide a broad range of diagnostic tests, including X-rays and electrocardiograms, and either has its own laboratory facilities or has reasonable access to such facilities;

"(4) maintains a unified medical record, stored in a central file, for each patient treated in such facility;

"(5) has arrangements with a general hospital and, to the extent possible, with convalescent institutions, home health agencies, and custodial care institutions to assure that services of such institutions will be available to patients of such facility when they can no longer be treated on an ambulatory basis;

"(6) provides preventive care services, including a health education program;

"(7) has a program of peer review to assure quality care and efficient utilization of services; and

"(8) has a program to utilize allied health personnel to assist its professional staff to the maximum extent practicable."

TITLE IV—PROVISIONS TO STRENGTHEN HEALTH PLANNING

Subtitle A—Health Report of the President; Health Policy Board

SEC. 401. HEALTH REPORT OF THE PRESIDENT.

The President shall transmit to the Congress not later than July 1 of each year, beginning in 1976, a health report (hereinafter referred to as the "health report") which shall set forth (1) the status and condition of the health care system of the Nation; (2) current and foreseeable trends in the health care needs of the Nation, the organization, financing, delivery, and quality of health care services, and the effects of those trends on the health of Americans and the social, economic, and other requirements of the Nation; (3) the adequacy of available manpower and physical resources for fulfilling the health care needs of the Nation in the light of expected population pressures; (4) a review of the health programs and activities of the Federal Government, the State and local governments, and nongovernmental entities, with particular reference to their contribution to the achievement of the policy set forth in title I of this Act; and (5) a program for carrying out the policy set forth in title I of this Act, together with recommendations for legislation.

SEC. 402. HEALTH POLICY BOARD.

There is created in the Executive Office of the President a Health Policy Board (hereinafter referred to as the "Board"). The Board shall be composed of three members who shall be appointed by the President to serve at his pleasure, by and with the advice and consent of the Senate. The President shall designate one of the members of the Board to serve as Chairman. Each member shall be a person who, as a result of his training, experience, and attainments is exceptionally well qualified to analyze and interpret trends in the health care field; to appraise programs and activities of the Federal Government in the light of the policy set forth in title I of this Act; and to formulate and recommend national policies to promote the improvement of health care.

SEC. 403. EMPLOYMENT OF OFFICERS, EMPLOYEES, EXPERTS AND CONSULTANTS.

The Board is authorized to employ and fix the compensation of such officers and employees as may be necessary to carry out its functions under this Act. In addition, the Board may employ and fix the compensation of such experts and consultants as may be necessary to carry out its functions under this Act in accordance with section 3109 of title 5, United States Code (but without regard to the last sentence thereof).

SEC. 404. RESPONSIBILITIES OF BOARD.

(a) GENERAL FUNCTIONS AND DUTIES.—It shall be the duty and function of the Board—

(1) to assist and advise the President in the preparation of the health report;

(2) to review and appraise the health programs and activities of the Federal Government in the light of the policy set forth in title I of this Act for the purpose of determining the extent to which such programs and activities are contributing to the achievement of such policy, and to make recommendations with request thereto;

(3) to develop and recommend procedures for the interagency coordination of Federal health programs, to propose interagency consolidations of programs and eliminations of programs to assure efficient, effective, and economic operation of all Federal health programs and to avoid waste and duplication;

(4) to develop and recommend goals for a national policy to foster and promote the improvement of the organization, financing, delivery and quality of the Nation's health care;

(5) to conduct studies, surveys, research, and analyses relating to health care in the Nation;

(6) to conduct a continuous evaluation of policies and programs related to the Nation's health care and make recommendations for the revision, expansion, and improvement of such policies and programs, including the assignment of priorities to the implementation of such recommendations in accordance with their relative urgency or desirability;

(7) to develop and recommend measures designed to assure the provision of adequate manpower, services, and facilities for the Nation's health care, including the mobilization, allocation, utilization, and retention of such manpower, services, and facilities;

(8) to develop and recommend guidelines for the allocation of funds for health care designed to furnish all citizens equal access to quality health care; and

(9) to make and furnish such studies, reports thereon, and recommendations with respect to matters of health care policy and legislation as the President may request.

(b) ANNUAL HEALTH REPORT TO THE PRESIDENT.—The Board shall submit to the President a first report not later than April 1, 1976, and an annual report not later than April 1 of each year thereafter. Each such report shall also be transmitted to the Congress supplementary to the next health report of the President.

(c) CONTENTS OF INITIAL ANNUAL HEALTH REPORTS.—In its first report and in the first of its annual reports to the President as required by subsection (b) of this section, the Board shall (1) specially report on all Federal programs which provide grants, loans, or other financial aids for the training and development of health manpower of any type; (2) appraise the adequacy of such programs to meet the health care needs of the Nation; (3) develop and recommend procedures for the consolidation, coordination, expansion, and improved efficiency of administration of such existing programs; and (4) develop and recommend measures designed to assure the wider dissemination of public information regarding the existence and purpose of such programs, the aids available thereunder, and the advantages and benefits of training for career opportunities in the health, nursing, and allied health professions.

SEC. 405. CONSULTATION WITH OTHER ADVISORY BODIES AND REPRESENTATIVE GROUPS; COOPERATIVE UTILIZATION OF SERVICES, FACILITIES, AND INFORMATION.

In exercising its powers, functions, and duties under this Act, the Board shall—

(1) consult with the National Council on Health Planning and Development established by section 1503 of title XV of the Public Health Service Act, with any other advisory council or committee required by Fed-

eral law, and with such representatives of consumer groups, providers of health care, health researchers and educators, insurers, health service organizations, public agencies concerned with health care, voluntary health and welfare organizations, and other groups, as it deems advisable;

(2) utilize, to the fullest extent possible, the services, facilities, and information (including statistical information) of public and private agencies and organizations, and individuals, in order that duplication of effort and expense may be avoided, thus assuring that the Board's activities will not unnecessarily overlap or conflict with similar activities authorized by law and performed by established agencies.

SEC. 406. COMPENSATION OF MEMBERS.

Members of the Board shall serve full time and the Chairman of the Board shall be compensated at the rate provided for level II of the Executive Schedule Pay Rates (5 U.S.C. 5313). The other members of the Board shall be compensated at the rate provided for level IV of the Executive Schedule Pay Rates (5 U.S.C. 5315).

SEC. 407. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums, not to exceed $1,000,000 in any fiscal year, as may be necessary to enable the Board to carry out its functions under this Act.

Subtitle B—Departmental Recommendations and Reports

SEC. 411. STATEMENTS REGARDING EFFECT OF DEPARTMENTAL PROPOSAL ON NATION'S HEALTH CARE.

(a) The Congress authorizes and directs that, to the fullest extent possible, all agencies of the Federal Government shall include in every recommendation or report on proposals for legislation and other major Federal actions significantly affecting human health and the organization, financing, delivery, and quality of the Nation's health care, whether with regard to all citizens generally or only to classes or segments of the public, a detailed statement by the responsible official on—

(1) the impact of the proposed action on human health and the Nation's health care system;

(2) any adverse effects which cannot be avoided should the proposal be implemented;

(3) alternatives to the proposed action;

(4) the relative priority, if any, assigned to the proposed action (or to any similar or alternative proposal designed to fulfill the same immediate purpose or need) by the Health Policy Board established by subtitle A of this title in its most recent report to the President submitted pursuant to section 404 (b) thereof; and

(5) any irreversible and irretrievable commitments of resources which would be involved in the proposed action should it be implemented.

(b) Prior to making any detailed statement required by subsection (a), the responsible Federal officials shall consult with and obtain the comments of any Federal agency which has jurisdiction by law or special expertise with respect to any impact on human health and the Nation's health care system. Copies of such statement and the comments and views of the appropriate Federal, State, and local agencies which have responsibilities in such areas shall be made available to the President, the Health Policy Board, and to the public as provided by section 552 of title 5, United States Code, and shall accompany the proposal through the existing agency review processes.

SEC. 412. AGENCY OBLIGATIONS UNDER OTHER FEDERAL STATUTES.

Nothing in section 411 shall in any way affect the specific statutory obligations of any Federal agency (1) to accord priorities or preferences to applications for Federal financial aids in public health and health care programs and activities, based on factors required to be considered by law or regulations pursuant thereto, (2) to coordinate or consult with any other Federal or State agency, or (3) to act, or refrain from acting, contingent upon the recommendations or certification of any other Federal or State agency.

TITLE V—PROVISIONS TO MAKE COMPREHENSIVE HEALTH CARE INSURANCE AVAILABLE TO ALL

Subtitle A—Establishment of Minimum Standard Health Care Benefits

SEC. 501. DEFINITION OF MINIMUM STANDARD HEALTH CARE BENEFITS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1954 is amended by redesignating section 220 as section 221, and by inserting after section 219 the following new section:

"SEC. 220. MINIMUM STANDARD HEALTH CARE BENEFITS.

"(a) IN GENERAL.—For purposes of this title, the minimum standard health care benefits for a covered individual for any given benefit year shall, subject to the other provisions of this section, be equal to the sum of—

"(1) 80 percent (50 percent in the case of items (b)(2)(C) and (b)(2)(N)) of the excess, if any, of the category I expenses incurred by the individual in that year over the deductible: *Provided*, That in no event shall the aggregate of the deductibles and copayments assessed in any given benefit year against the category I expenses incurred in that year by all covered members of a given family exceed an amount equal to ten times the deductible applicable to that year, and

"(2) 100 percent of the category II expenses incurred by the individual in that year.

"(b) CATEGORY I EXPENSES.—

"(1) Prior to January 1, 1985, category I expenses shall be the charges for the services and articles described in items (A) through (L) of subsection (b) (2) and the items described in subsection (c) (2).

"(2) On and after January 1, 1985, category I expenses shall be the charges for the following services and articles:

"(A) hospital inpatient services and hospital outpatient services not then included in category II,

"(B) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician or, at his direction, by his staff of registered graduate nurses (RN) and allied health professioinals, and which are not included in category II,

"(C) the first twenty professional services for the diagnosis or treatment of one or more mental conditions rendered during the year by a community mental health center or by one or more physicians, or, at their direction, by their staffs of registered graduate nurses (RN) and allied health professionals,

"(D) drugs and contraceptive devices requiring a physician's prescription,

"(E) services of a skilled nursing facility for not more than 180 days in a year, provided use of these services commences within 14 days of the termination of a hospital confinement which lasted at least 3 days and which was for the same or a related condition,

"(F) services of a home health agency up to a maximum of 270 services in a year, provided use of these services commences within 14 days of the termination of a hospital confinement which lasted at least 3 days and which was for the same or a related condition,

'(G) use of radium or other radioactive materials,

(H) oxygen,

"(I) anesthetics,

"(J) prostheses, other than dental,

"(K) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed, "(L) oral surgery for excision of:

"(i) partially or completely unerupted impacted teeth, or

"(ii) a tooth root without extraction of the entire tooth,

"(M) analgam, acrylic, synthetic porcelain, and composite fillings and extractions including general anesthetic in connection therewith; injection of antibiotic drugs which are rendered by a dentist or, at his direction, by his staff of allied health professionals,

"(N) other dental services and prostheses, exclusive of orthodontia, which are rendered by a dentist or, at his direction, by his staff of allied health professionals, and which are not then included in category II,

"(O) services of a physical therapist,

"(P) services of a speech therapist,

"(Q) one eye refraction every 3 years by a physician for individuals age 13 or older,

"(R) one pair of eyeglasses per prescription, with a limit of one prescription per year for an individual under age 19 and one prescription every 3 years for an individual age 19 or older; with contact lenses considered as a pair of eyeglasses only when required as an integral part of intraocular surgery,

"(S) one hearing examination every 3 years by a physician or audiologist,

"(T) one hearing aid every 3 years for individuals under age 19 and one per lifetime for individuals age 19 or older,

"(U) one physical examination every 5 years for individuals age 5 years or older.

"(c) CATEGORY II EXPENSES.—

"(1) Prior to January 1, 1985, there shall be no category II expenses.

"(2) On and after January 1, 1985, category II expenses shall be the charges for the following services and articles:

"(A) diagnostic X-rays and laboratory tests, performed other than while an inpatient in a hospital or skilled nursing facility,

"(B) well child care, including immunizations, for children under age 5,

"(C) one oral examination per year, including prophylaxis, dental X-rays, topical application of fluoride and insertion of space maintainers, by a dentist or, at his discretion, a dental hygienist, for children under age 13, "(D) one eye refraction per year by a physician for children under age 13,

"(E) counseling on family planning and fitting of contraceptive device by a physician or an authorized member of his staff,

"(F) one Papanicolaou smear test every 2 years for women age 19 or over.

"(d) DEDUCTIBLES.—The deductible for each benefit year commencing prior to January 1, 1978, shall be $100. The deductible for each benefit year commencing on or after January 1, 1978, shall be $100 times the ratio of the Consumer Price Index for July of the calendar year next preceding the calendar year in which the benefit year commences to the Consumer Price Index for July 1976, which product, if not an even multiple of $10, shall be taken to the next lower multiple of $10. Covered expenses incurred and actually applied toward an individual's deductible during the last 3 months of 1 benefit year shall be carried over and applied toward the deductible of that person for the following benefit year.

"(e) EXCLUSIONS.—Charges for the services and articles specified in subsections (b) and (c) do not include any of the following:

"(1) Any charge for any care for any injury or disease either—

"(A) arising out of and in the course of an employment subject to a workmen's compensation or similar law, or

"(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any liability insurance policy or equivalent self-insurance,

"(2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of a nonoccupational injury,

"(3) any charge for travel, other than travel by local professional ambulance to the nearest health care institution qualified to treat the illness or injury,

"(4) any charge for confinement in a private room to the extent the charge is in excess of the institution's charge for its most common semiprivate room,

"(5) any charge by health care institutions to the extent that it is determined under section 2008 of title XX of the Social Security Act that the charge exceeds the rates approved thereunder,

"(6) any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel to the extent that it is determined under the procedures established in section 2002(d)(1) of title XX of the Social Security Act that the charge is unreasonable or that the services or articles for which the charge is made are not necessary,

"(7) any charge for services or articles, the provision of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles,

"(8) any charge for the treatment of flat foot conditions or the prescription of supportive devices therefor, the treatment of subluxations of the foot, or routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care) except when the patient is being treated for a peripheral-vascular disease that is so severe that routine foot care not under the direct supervision of a physician would be hazardous to the patient, or

"(9) any charge for orthoptics (eye exercises).

"(f) DEFINITIONS.—In applying this section—

"(1) the term 'physician' means an individual who is licensed or certified by the State as a doctor of medicine; doctor of osteopathy; doctor of podiatry; doctor of optometry; for purposes of oral surgery, doctor of dental surgery or doctor of medical dentistry; and, for purposes of mental conditions, a psychologist who meets the conditions set forth in (2).

"(2) The term 'psychologist' means a person who is duly licensed or certified as a psychologist and has a doctoral degree in clinical psychology and at least 2 years of supervised experience in clinical psychology at a licensed hospital or community mental health center.

"(3) The terms 'skilled nursing facility,' 'home health agency' and 'hospital' (herein referred to as 'health care institutions'), and 'home health services' shall have the meanings assigned to them in section 1861 of the Social Security Act.

"(4) The term 'copayment' means the portion of category I charges that is not payable by a qualified health care plan and which is thus the obligation of the covered individual concerned to pay.

"(5) The term 'covered individual' means an individual who is covered under a qualified health care plan, except that an individual covered under a qualified employee health care plan who is not required to be so covered pursuant to section 280(c)(5) shall not be treated as a covered individual unless he is eligible under such plan for at least the minimum standard health care benefits.

"(6) The term 'qualified health care plan' means a qualified employee health care plan (as defined in section 280(c) of the Internal Revenue Code of 1954), a qualified individual health care plan (as defined in section 213(g) of the Internal Revenue Code of 1954) and a qualified State health care plan (as defined in section 2002 of the Social Security Act).

"(7) The term 'confinement' means confinement on an inpatient basis in a health care institution.

"(8) The term 'community mental health center' means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill persons, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which the facility is situated.

"(9) The term 'benefit year' means a period of 12 consecutive months during which the deductible must be met."

"(g) LIMITATIONS ON MALPRACTICE JUDGMENTS.—In any litigation in any court of the United States or any State seeking damages for injury caused by negligence or other fault in the furnishing of any service or article covered under a qualified health care plan or under any title of the Social Security Act, no damages shall be awarded for the cost of remedial services for which the injured party was or is entitled to have payment made under this Act (or for which he would have been, or would be, entitled to have payment made upon obtaining the services from a physician or health care institution)."

(b) CONFORMING CLERICAL AMENDMENT.—The table of sections for such part VII is amended by striking out the last item and inserting in lieu thereof:

"Sec. 220. Minimum standard health care benefits.
"Sec. 221. Cross references."

Subtitle B—Qualified Employee Health Care Plans

SEC. 511. EMPLOYER'S DEDUCTION FOR EMPLOYEE HEALTH CARE EXPENDITURES.

(a) IN GENERAL.—Part IX (relating to items not deductible) of subchapter B of chapter 1 of subtitle A of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new section:

"SEC. 280. EMPLOYER'S DEDUCTION FOR EXPENDITURES FOR EMPLOYEE HEALTH CARE.

"(a) LIMITATION ON DEDUCTION.—Except as provided in subsection (b), no deduction shall be allowed for the disallowed percentage of any amount otherwise allowable as a deduction for the taxable year under section 162, 212, or 404 for any amount paid or incurred by the taxpayer for medical care of any employee of the taxpayer, the employee's spouse, or any dependent of the employee. The disallowed percentage of the amount referred to in the preceding sentence is—

"(1) 50 percent if the amount is paid or incurred in 1977,

"(2) 75 percent if the amount is paid or incurred in 1978, and

"(3) 100 percent if the amount is paid or incurred after 1978.

"(b) EXCEPTIONS AND LIMITATIONS.—Subsection (a) shall not apply to any amount paid or incurred by the taxpayer—

"(1) WHERE EMPLOYER MAINTAINS QUALIFIED EMPLOYEE HEALTH CARE PLAN.—For any portion of the taxable year during which the taxpayer has in force a qualified employee health care plan which satisfies all the requirements of subsection (c).

"(2) TAXES.—As a tax imposed by the United States, a possession of the United States, a State, or a political subdivision of the foregoing, or by the District of Columbia.

"(3) MEDICAL CARE PROVIDED DIRECTLY BY EMPLOYER.—To directly provide medical care, through health care personnel who are employees of the taxpayer, principally for employees of the taxpayer, or to acquire or maintain equipment or supplies to be used by such personnel for such purpose.

"(c) QUALIFIED EMPLOYEE HEALTH CARE PLAN DEFINED.—For the purposes of this title, the term 'qualified employee health care plan' means a plan of employee health care benefits (as defined in subsection (d) (4)) which satisfies all of the following requirements:

"(1) IN WRITING.—The plan must be in writing.

"(2) ADOPTED BY EMPLOYER.—The plan must be adopted by the taxpayer employer except that trustee plans established pursuant to the Labor Management Relations Act of 1947 shall be deemed to be adopted by the employer.

"(3) COMMUNICATION TO EMPLOYEES.—The terms of the plan must be communicated by the taxpayer to his employees.

"(4) MINIMUM STANDARD HEALTH CARE BENEFITS.—The plan must provide at least the minimum standard health care benefits described in section 220.

"(5) ELIGIBILITY.—The plan must be one under which the individuals eligible to be covered include at least—

"(A) each qualified employee of the taxpayer,

"(B) any such employee's spouse, and

"(C) any such employee's dependent unmarried child who is either under age 19 or under age

25 and a full-time student at an accredited institution of learning.

"(6) COVERAGE CONTINUATION.—The plan must provide for continuation of coverage under each of the following circumstances:

"(A) Upon layoff or termination of employment, other than as a result of death of the employee, the employee must be permitted to have coverage under the plan continued for himself and for his covered dependents to the end of the second calendar month following the calendar month in which employment terminated.

"(B) Upon the death of an employee, his covered dependents must be permitted to have coverage under the plan continued to the end of the second calendar month following the calendar month in which death occurred.

"(C) During an employee's absence due to illness or injury, coverage for the employee and his covered dependents must be permitted to continue for up to 30 months from the beginning of such absence.

"(D) Coverage for an employee's dependent unmarried child must be permitted to continue beyond the child's 19th birthday, if the child was covered under the plan prior to attaining age 19, became totally disabled prior to that age, and remains so disabled. The employee must not be required to contribute more for such coverage than would have been required were the child a dependent under age 19.

"(E) Any employee or dependent entitled to continuation of coverage under any of the above subparagraphs at a time when the employer changes his plan and who would thereby lose his continuation of coverage, must be eligible under any successor plan for not less than the continuation of the coverage that would have been required to be continued had the prior plan remained unchanged.

"(F) For purposes of this paragraph, a 'covered dependent' is any individual, other than the employee, who by reason of his relationship to the employee was covered as a dependent under the plan just prior to the event described in subparagraph (A), (B), or (C). A child born after the event described in subparagraph (A), (B), or (C) but before the end of the continuation period so specified, shall be deemed a covered dependent. Coverage for a covered dependent shall not be required to be continued beyond the date the dependent would have ceased to be eligible for coverage as a dependent if the event described in subparagraph (A), (B), or (C) had not occurred.

"(H) Notwithstanding subparagraphs (A), (B), and (C), coverage need not be continued for a covered individual beyond the date such individual first becomes eligible for benefits under title XVIII of the Social Security Act.

"(7) COORDINATION OF BENEFITS PROVISION.—The plan must include a provision identical with or substantially similar to the suggested model group antiduplication provision as modified and interpreted in the report of the industry task force on coordination of benefits attached to the report of the C–1 Accident and Health Protection Subcommittee as set forth in Volume I of the 1971 proceedings of the National Association of Insurance Commissioners.

"(8) OPTIONAL PROVISIONS.—The plan shall not be treated as failing to meet the requirements of this subsection by reason of the inclusion therein of any one or more of the following optional provisions:

"(A) DEDUCTIBLE.—The plan may require a lesser deductible or waive it entirely with respect to one or more items of covered expense.

"(B) COPAYMENTS.—The plan may require lesser copayments or none at all with respect to one or more items of covered expense.

"(C) ADDITIONAL BENEFITS AND COVERAGE.—The plan may provide any benefits for medical care in addition to the minimum standard health care benefits described in section 220 and may also cover any individual in addition to the individuals required under paragraph (5) to be made eligible for coverage.

"(D) EMPLOYEE CONTRIBUTIONS.—The plan may require employee contributions toward its cost; except that the maximum employee contribution shall not exceed the lesser of—

"(i) 100 percent of the premium rate currently charged under the plan for the employee's coverage for himself and his then covered dependents, if any; or

"(ii) 10 percent of the excess, if any, of the employee's wages paid by the employer during the preceding calendar month over one-twelfth of the amount specified in section 2006 (g) of title XX of the Social Security Act.

When a plan requires employee contributions, the plan must provide each eligible employee who is not then enrolled a period of at least 30 days each year in which to decide whether to enroll in the plan. An employee who elects not to enroll during any such period will not again be eligible to enroll until the next such period.

"(d) DEFINITIONS.—For purposes of this section—

"(1) EMPLOYEE.—The term 'employee' shall have the meaning prescribed by section 3121 (d).

"(2) MEDICAL CARE.—The term 'medical care' shall have the meaning prescribed by paragraph (1) without regard to paragraphs (2) and (3) of section 213 (e).

"(3) DEPENDENT.—The term 'dependent' as used in this section in reference to a dependent of an employee means an individual over half of whose support, for the calendar year in which the taxable year of such employee begins, was received from such employee.

"(4) PLAN OF EMPLOYEE HEALTH CARE BENEFITS.—The phrase 'plan of employee health care benefits' as used in subsection (c) includes—

"(A) a contract or contracts of insurance (whether one or more group contracts or a group of individual contracts) covering medical care for employees;

"(B) any uninsured arrangement established by an employer to provide medical care for employees;

"(C) an arrangement to secure medical care for employees from any approved health maintenance organization;

"(D) any insured or uninsured trustee arrangement set up pursuant to the Labor Management Relations Act of 1947; and

"(E) any combination of contracts or arrangements described in subparagraphs (A), (B), (C) or (D).

"(5) APPROVED HEALTH MAINTENANCE ORGANIZATION.—The term 'approved health maintenance organization' shall have the meaning prescribed by section 2015(m) of title XX of the Social Security Act.

"(6) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to any employer, any employee who—

"(A) either—

"(i) has been such an employee for more than 2 calendar months; or

"(ii) furnishes the employer proof that on the day before he became an employee of that employer he was covered and had been continuously covered for at least 2 calendar months under either another qualified employee health care plan or a qualified State health care plan and is now no longer eligible for coverage or continuation of coverage under such qualified health care plan; and

"(B) either—

"(i) is considered to be a full-time employee; or

"(ii) is not considered to be a full-time employee, but who is expected to work at least 20 hours a week for at least 26 weeks during the next 12 months; or

"(iii) is not considered to be a full-time employee, but who has actually worked at least 20 hours a week for at least 26 weeks during the previous 12 months:

Provided, however, That, as to trustee plans established pursuant to the Labor Management Relations Act of 1947, the term 'qualified employee' means a person eligible to be covered under such trustee plan."

"(7) CHILD.—The term 'child' means a son or daughter of the employee including a legally adopted son or daughter."

(b) CONFORMING CLERICAL AMENDMENTS.—

(1) Section 162 (h) of the Internal Revenue Code of 1954 (relating to cross references) is amended by adding at the end thereof the following new paragraph:

"(3) For limitation on employer's deduction for employee health care, see section 280."

(2) Section 404 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

"(g) CROSS REFERENCE.—

"For limitation on employer's deduction for employee health care, see section 280."

(3) Section 212 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following cross reference:

"CROSS REFERENCE.—

"For limitation on employer's deduction for employee health care, see section 280."

(4) The table of sections for part IX of subchapter B of chapter I of subtitle A of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new item:

"Sec. 280. Employer's deduction for expenditures for employee health care."

(c) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years ending after December 31, 1976.

(2) CERTAIN COLLECTIVELY BARGAINED PLANS.—In the case of any plan providing benefits for medical care of employees which was established by an employer taxpayer pursuant to an agreement which resulted from collective bargaining between the employer and representatives of his employees and which has not expired at the time specified in paragraph (1), the amendments made by this section shall not apply to such employer taxpayer until the first taxable year beginning after the last date such agreement is in effect or the date two years after the time specified in paragraph (1), whichever such date occurs first.

Subtitle C—Qualified Individual Health Care Plans

SEC. 521. QUALIFIED INDIVIDUAL HEALTH CARE PLANS.

(a) UNLIMITED DEDUCTION FOR MEDICAL INSURANCE EXPENSES OF INDIVIDUAL COVERED BY QUALIFIED HEALTH CARE PLAN.—Section 213 (a) (2) (relating to individual's deduction for medical insurance expense) of the Internal Revenue Code of 1954 is amended to read as follows:

"(2) the sum of—

"(A) an amount (not in excess of $150) equal to one-half of the expenses (other than those deductible under subparagraph (B)) paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents (as defined in section 152); and

"(B) in the case of a taxpayer who at any time during the taxable year is covered under a qualified health care plan (as defined in section 220), an amount equal to all the expenses paid during the taxable year for any insurance (whether provided under such qualified health care plan or otherwise) which constitutes medical care for the taxpayer, his spouse, or dependents (as defined in section 152), and which constitutes coverage during such portion of the taxable year as the taxpayer is covered by such qualified health care plan."

(b) DEFINITION OF QUALIFIED INDIVIDUAL HEALTH CARE PLAN.—Section 213 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

"(g) QUALIFIED INDIVIDUAL HEALTH CARE PLAN DEFINED.—For purposes of this title, the term 'qualified individual health care plan' means insurance which covers medical care referred to in subparagraphs (A) and (B) of subsection (e)(1), as modified by paragraphs (2) and (3) of subsection (e), and which satisfies all of the following requirements:

"(1) MINIMUM STANDARD HEALTH CARE BENEFITS.—The plan must provide at least the minimum standard health care benefits described in section 220.

"(2) CONTRACT REQUIREMENTS.—Each contract of insurance forming a part of the plan must contain provisions—

"(A) which obligate the insurer to renew the contract until the earlier of—

"(i) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under title XVIII of the Social Security Act, or

"(ii) July 1 of the year in which the insurer shall have given at least 120 days prior notice that it is nonrenewing all contracts issued in that State that either then qualify under subsection (g) or previously have so qualified and that it will no longer issue such contracts, and which also reserve to the insurer the right to adjust premium rates by classes in accordance with its experience under the type of contract involved;

"(B) which, if issued prior to January 1, 1985, enable the individual in whose name the contract was issued to secure on January 1, 1985, without evidence of insurability, the minimum standard health care benefits then effective; and

"(C) which, upon the death of the individual in whose name the contract was issued, permit every other individual then covered under the contract to elect (within such period as shall be specified in the contract) to continue his coverage (under the same or a different contract) until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

"(3) OPTIONAL PROVISIONS.—An insurance contract shall not be treated as failing to meet the requirements of this subsection by reason of the inclusion therein of any one or more of the following optional features:

"(A) INSURANCE WITH OTHER INSURERS.—The contract may contain a provision coordinating its benefits with any other contract if such provision is approved by the appropriate regulatory authority of the State of issue.

"(B) DEDUCTIBLES.—The contract may require a lesser deductible or waive it entirely with respect to one or more items of covered expense.

"(C) COPAYMENTS.—The contract may require lesser copayments or none at all with respect to one or more items of covered expense.

"(D) ADDITIONAL BENEFITS.—The contract may provide any benefits for medical care in addition to the minimum standard health care benefits."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 1976.

SEC. 522. PROCEDURE FOR RULINGS ON QUALIFICATION OF EMPLOYEE AND INDIVIDUAL HEALTH CARE PLANS.

In exercise of the power to issue rulings which is vested in him under section 7805 of the Internal Revenue Code of 1954, the Secretary of the Treasury (or his delegate) may accept the determination of the state insurance regulatory authority that a plan of health care benefits filed with and approved by such authority is a plan satisfying all requirements for qualification either as a qualified employee health care plan (as defined in section 280(c) of the Internal Revenue Code of 1954) or as a qualified individual health care plan (as defined in section 213(g) of the Internal Revenue Code of 1954).

SEC. 523. REGULATIONS.

Any regulations promulgated by the Secretary of the Treasury (or his delegate) with regard to amendments of the Internal Revenue Code of 1954 made by subtitle A, B, or C of this title shall be promulgated in final form not less than 120 days prior to the first day of the calendar year during which they will apply. Such regulations shall be effective only if (a) promulgated in final form within the time prescribed in the preceding sentence, and (b) notice of such regulation in proposed form and of opportunity for public hearing thereon shall have been published not less than 60 days prior to the date of promulgation thereof in final form.

Subtitle D—Grants to States for Qualified State Health Care Plans for the Needy

SEC. 531. GRANTS TO STATES FOR QUALIFIED STATE HEALTH CARE PLANS.

The Social Security Act is amended by adding after title XIX the following new title:

“TITLE XX—GRANTS TO STATES FOR QUALIFIED STATE HEALTH CARE PLANS

“Sec. 2001. Appropriations.
“Sec. 2002. Qualified State Health Care Plan definition.
“Sec. 2003. Eligibility for enrollment.
“Sec. 2004. Determination and review of premium rates.
“Sec. 2005. Procedure for enrollment.
“Sec. 2006. Individual and family contributions and State premium payments.
“Sec. 2007. Extension and termination of coverage.
“Sec. 2008. Approval of institutional rates of reimbursement by State Health Care Institutions Cost Commissions.
“Sec. 2009. Review of levels of institutional rates of reimbursement by Secretary of Health, Education, and Welfare.
“Sec. 2010. Operation of the Qualified State Health Care Benefits Pool.
“Sec. 2011. Furnishing of information by other agencies.
“Sec. 2012. Payments to States.
“Sec. 2013. Eligibility of those now covered under certain State or Federal programs.
“Sec. 2014. Premium taxes.
“Sec. 2015. Definitions.
“Sec. 2016. Protection against insolvency.
“Sec. 2017. Regulations.
“Sec. 2018. Underwriting and reinsurance facilities.

“AUTHORIZATION OF APPROPRIATIONS

“Sec. 2001. For the purpose of providing comprehensive health care insurance to needy individuals and families in a manner which will enhance personal dignity, there is authorized to be appropriated for each fiscal year a sum sufficient to carry out this title. The sums appropriated pursuant to this section shall be used for making payments to qualified State health care plans which have been approved by the Secretary of Health, Education, and Welfare.

"QUALIFIED STATE HEALTH CARE PLAN DEFINITION

"General Rule

"SEC. 2002. (a) A qualified State health care plan shall be a contract or other agreement between a State and an administering carrier designated by the State with the approval of the Secretary, which provides for payment to practitioners, health care institutions, and other providers, on behalf of the individuals and families required under section 2003 to be made eligible therefor, the minimum standard health care benefits described in section 220 of the Internal Revenue Code of 1954, subject to the modifications specified in (c).

"Option To Elect Coverage Under an Approved Health Maintenance Organization

"(b) An individual or family eligible for enrollment in the qualified State health care plan under section 2003 may, upon written request, submitted to the administering carrier with his enrollment application, elect coverage, if available, under an arrangement between the administering carrier and an approved health maintenance organization (as defined in section 2015(m)), in lieu of coverage under the qualified State health care plan: *Provided, however,* That the charges made to the State through the administering carrier for such alternative coverage shall not exceed the average charge that would have been made to the State had the individual or family not made such election and had enrolled instead in the qualified State health care plan.

"Reinsurance Condition

"(c) The contract risk under a qualified State health care plan shall be reinsured, through the qualified State health care benefits pool described in section 2010, by all carriers (profit and nonprofit) licensed in or otherwise authorized by the State to issue coverage for one or more items of health care, by all approved health maintenance organizations doing business in the State, and by all other persons in the State who provide uninsured plans that are qualified employee health care plans (as defined in section 280 of the Internal Revenue Code of 1954).

"Deductible

"(d) (1) The amount of the deductible for any given policy year shall be the figure shown in the first column of table A corresponding to the applicable adjusted gross income shown in table A for the size of family concerned.

"Table A

Deductible	Adjusted gross income		
	Single individual	Family of 2	Family of 3 or more
$10	Less than $1,000	Less than $1,500	Less than $2,000.
$20	$1,000 but less than $1,500	$1,500 but less than $2,250	$2,000 but less than $3,000.
$30	$1,500 but less than $2,000	$2,250 but less than $3,000	$3,000 but less than $4,000.
$40	$2,000 but less than $2,500	$3,000 but less than $3,750	$4,000 but less than $5,000.
$50	$2,500 but less than $3,000	$3,750 but less than $4,500	$5,000 but less than $6,000.
$60	$3,000 but less than $3,500	$4,500 but less than $5,250	$6,000 but less than $7,000.
$70	$3,500 but less than $4,000	$5,250 but less than $6,000	$7,000 but less than $8,000.
$80	$4,000 but less than $4,500	$6,000 but less than $6,750	$8,000 but less than $9,000.
$90	$4,500 but less than $5,000	$6,750 but less than $7,500	$9,000 but less than $10,000.

"(2) At such times as the operation of section 2003 (a) (4) may cause individuals or families with adjusted gross incomes in excess of those shown in table A to become eligible for the qualified State health care plan, the deductible applicable to such individuals or families shall be determined by adding to $90—

"(A) $10 for each $500 or fraction thereof by which the adjusted gross income of a single individual exceeds $5,000,

"(B) $10 for each $750 or fraction thereof by which the adjusted gross income of a family of two exceeds $7,500, or

"(C) $10 for each $1,000 or fraction thereof by which the adjusted gross income of a family of three or more exceeds $10,000.

"(3) For the purpose of this subsection, the adjusted gross income to be used shall be that for the last taxable year preceding April 1 of the calendar year in which the policy year commences.

"(4) Covered expenses incurred and actually applied toward an individual's deductible during the last three months of one policy year shall be carried over and applied toward the deductible of that person for the following policy year.

"(5) The limit on the aggregate of deductibles and copayments assessed in any one policy year shall be ten times the amount of the deductible determined for that policy year.

"Limitations

"(e) (1) (A) No charge for a benefit otherwise described by this section, other than charges by a health care institution, shall be reimbursed to the extent that it exceeds a reasonable charge. In determining the reasonable charge for a given health care service or article there shall be taken into consideration the charge for the service or article when rendered under comparable conditions, which is customarily made by the physician, or other person furnishing such service or article, but in no event shall the payment be in excess of the prevailing charge in the locality for the service or article. The prevailing charge in a locality for the period from July 1 of a given calendar year through June 30 of the following calendar year shall be the amount which the administering carrier determines to be the seventy-fifth percentile of a low to high distribution of the actual charges made for similar services or articles by all physicians in the same locality during the calendar year immediately preceding the given year. However, if the percentage increase in the prevailing charge (so determined) from one period to the next would be greater than the percentage increase in the Consumer Price Index during the preceding calendar year, then the prevailing charge for such next period shall be that used for the prior period increased by the same percentage increase as had occurred in the Consumer Price Index. When for any reason in any given period this method of calculation shall produce a prevailing charge for any service or article which in the opinion of the administering carrier is unreasonable or inequitable, the prevailing charge for that service or article in that period shall be determined by the administering carrier in accordance with regulations specified by the Secretary for this purpose.

"(B) No charge by a physician (as defined in section 220(f)(1) of the Internal Revenue Code of 1954) for a benefit otherwise described by this section shall be reimbursed to the extent that it is for health care services or articles rendered by the physician or at his direction and determined not to be necessary according to utilization guidelines that have been established by physicians deemed competent by their peers. Payment for health care services or articles beyond such guidelines may be made only if approved by the health professional staff of the administering carrier of the qualified State health care plan, after review by a professional standards review organization established by the physicians of the locality, if such exists, pursuant to part B of title XI of the Social Security Act.

"(C) No charges for care rendered in any health care institution shall be reimbursed if it is determined, in accordance with and subject to the provisions of section 2008, that the health care institution is not complying with the prospective rate approval conditions established by section 2008.

"(2) No charge for a benefit otherwise described by this section shall be reimbursed to the extent it is a proper reimbursement or would be in the absence of this title under any other insurance plan providing health care benefits, including, but not limited to, benefits provided under title XVIII of the Social Security Act.

"Optional Election of Services of Christian Science Practitioner

"(f) An individual or family eligible for enrollment in a qualified State health care plan under section 2003 may elect, in writing, at the time the individual or family makes application for enrollment, to have the term 'physician' mean 'a Christian Science practitioner listed as such in the Christian Science Journal current at the time the practitioner provides the service' in lieu of the meaning set forth in section 220(f)(1) of the Internal Revenue Code of 1954. Such election shall not apply to any service or article furnished in connection with a pregnancy or any complication thereof.

"ELIGIBILTY FOR ENROLLMENT

"Needy Individuals and Families

"SEC. 2003. (a) Every individual or family (as defined in section 2015(1))—

"(1) who is a resident of the State;

"(2) who is not eligible to enroll (through either spouse in the case of a family) in a qualified employee health care plan (as described by section 280(c) of the Internal Revenue Code of 1954);

"(3) who, if eligible to enroll in the supplementary medical insurance program for the aged described in part B of title XVIII of the Social Security Act, is, in fact, enrolled in said insurance program; and

"(4) who meets one of the three following conditions—

"(A) whose adjusted gross income for his or its last taxable year preceding April 1 of the calendar year in which the policy year, for which eligibility is being determined, commences was less than—

"(i) $5,000 times the ratio specified in item (5) for a single individual,

"(ii) $7,500 times the ratio specified in item (5) for a family of two, or

"(iii) $10,000 times the ratio specified in item (5) for a family of three or more; or

"(B) who does not meet condition (A) but who furnishes the administering carrier satisfactory evidence that his or its adjusted gross income was less than one-twelfth of the dollar limit applicable to the policy year concerned—

"(i) under item (a) (4) (A) (i) for a single individual,

"(ii) under item (a) (4) (A) (ii) for a family of two, or

"(iii) under item (a) (4) (A) (iii) for a family of three or more;

for each of the last 2 calendar months, who agrees that his or its continued eligibility during that policy year will be contingent upon furnishing satisfactory proof that his or its adjusted gross income for each succeeding calendar month is below the applicable amount specified above and who furnishes such proof prior to the last day of the calendar month next following the month with respect to which proof is furnished; or

"(C) does not meet either condition (A) or (B) above but is a Federal cash recipient as defined in section 2015 (i),

shall, in accordance with, and subject to the other provisions of this title, be eligible to enroll in the qualified State health care plan;

"(5) the ratio referred to in item (4)(A) is the ratio of the Consumer Price Index for July of the calendar year next preceding the calendar year in which the policy year concerned commences to the Consumer Price Index for July, 1976, which ratio, if not an even multiple of 10 percent shall be taken to the next lower multiple of 10 percent.

"Time for Determining Eligibility

"(b) For the purpose of applying the conditions of eligibility under this section, all determinations shall be made on the day application for enrollment for the policy year is made.

"DETERMINATION AND REVIEW OF PREMIUM RATES

"General Rule

"SEC. 2004. (a) The premium rate to be charged under a qualified State health care plan for each policy year shall be actuarially established in each State for each of the risk categories—

"(1) single individual,

"(2) family of two, and

"(3) family of three or more.

"Composition of Premium

"(b)(1) The premium rate for a given risk category to be charged for the initial policy year shall be determined by the administering carrier on the basis of the sum of only the following factors:

"(A) the arithmetic average of the separate estimates of incurred claim costs for that risk category for the first policy year filed with the insurance regulatory authority of the State pursuant to requests by such authority to two nondomestic insurance companies licensed to issue health care insurance in the 50 States and the District of Columbia, two domestic insurance companies licensed to issue health care insurance in the State, one domestic nonprofit hospital expense indemnity organization, and one domestic nonprofit medical expense indemnity organization;

"(B) the charge for administration as set for the policy year by the administering carrier; and

"(C) a risk charge in an amount mutually agreed upon from time to time by the insurance commissioner, the administering carrier, and three members of the American Academy of Actuaries with experience in health care insurance, two of whom are appointed by the Governor of the State and one by the administering carrier.

"(2) The premium rate for a given risk category to be charged for each subsequent policy year shall be determined by the administering carrier on the basis of the sum of only the following factors:

"(A) the incurred claim costs for that risk category for the prior policy year;

"(B) an amount equal to any projected increase or decrease in incurred claim costs for that risk category for the policy year;

"(C) an amount, if needed, to repay in full any pool losses (described in subsection 2010(c)) of prior years borne by the reinsurers of the pool and not yet recovered by them;

"(D) the charge for administration as set for the policy year by the administering carrier; and

"(E) the risk charge established pursuant to subsection (b)(1)(C).

"Review of the Premium Rates

"(c)(1) The premium rates determined for each State for each policy year pursuant to subsection (b) and the utilization and other assumptions underlying the rates are to be filed by the State with the chief actuary for the Social Security Administration, and if, within ninety days after such filing, the chief actuary determines that the rates are unjustifiably high for the State, he shall recommend to the Secretary a commensurate reduction in the Federal health care percentage described in section 2012(d). The Secretary, to the extent he concurs in and adopts such recommendation, shall advise the State of the reduction he proposes to promulgate.

"(2) The State may request a hearing within 30 days after receipt of notice of the proposed reduction pursuant to paragraph (1). In such event, the Secretary shall, upon request by the State for a hearing and within 30 days thereof, appoint a hearing board of three actuaries, each of whom shall be a member in good standing of the American Academy of Actuaries, including one actuary who shall be appointed with the concurrence of the Governor of the State, and one actuary who shall be appointed with the concurrence of the administering carrier.

"(3) If a State does not request a hearing, or if the hearing board appointed pursuant to paragraph (2) concurs in the finding that the rates are unjustifiably high, the Secretary shall promulgate the proposed reduction in the Federal health care percentage, which shall apply throughout the period that the rates on which the hearing was based remain in effect.

"(4) If the hearing board appointed pursuant to paragraph (2) determines that the rates are not unjustifiably high for the State, the Federal health care percentage shall not be reduced.

"PROCEDURE FOR ENROLLMENT

"General Rule

"SEC. 2005. (a) (1) The appropriate State agency shall enroll each Federal cash recipient, required under section 2003 to be made eligible therefor, in the qualified State health care plan, and shall file his application with the administering carrier on forms to be provided by the administering carrier.

"(2) All other individuals, or the member of a family who provides the family's chief support, otherwise required under section 2003 to be made eligible therefor, may enroll in a qualified State health care plan upon filing an application with the administering carrier on a form to be provided by the administering carrier.

"Information Required of Each Applicant

"(b) Each eligible applicant described in section 2003 shall provide the administering carrier all information and evidence required to make an eligibility determination, and provide or certify any other essential information required under regulations prescribed by the Secretary, including but not limited to—

"(1) certification of his eligibility as a Federal cash recipient;

"(2) certification of his, or his family's adjusted gross income;

"(3) certification that he and his applicable family members, if eligible for the supplementary medical insurance program for the aged described in part B of title XVIII of the Social Security Act, are enrolled thereunder; or, if not then eligible, certify that he and his applicable family members who may become eligible during the policy year for the insurance program described in part B of title XVIII will enroll in such program; and

"(4) permission for the administering carrier to confirm his, or his family's, adjusted gross income with the Internal Revenue Service.

"Enrollment Periods

"(c) Applications for enrollment in a qualified State health care plan shall only be made and filed during an open enrollment period which shall be the calendar month of April of each year for coverage commencing for the policy year beginning the following July 1, except applications for enrollment—

"(1) shall be made by the appropriate State agency on behalf of an individual or family who establishes (other than during an open enrollment period) that he is a Federal cash recipient eligible for enrollment pursuant to section 2003 (a), but not then enrolled; and shall be filed with the administering carrier by the appropriate State agency within thirty days following the day on which the State receives satisfactory evidence that such individual or family has established eligibility as a Federal cash recipient; or

"(2) may be made by an individual or family who is not a Federal cash recipient and who is currently eligible for enrollment pursuant to section 2003 (a) but was not so eligible at the time of the last open enrollment period and, if so made, shall be filed with the administering carrier by the individual or family within 30 days following the first day, after the last open enrollment period, on which such individual or family so became eligible.

"Effective Date of Coverage

"(d) Qualified State health care plan coverage for an individual or family eligible to enroll shall commence on the first day of the third calendar month following the calendar month in which application for enrollment was filed with the administering carrier, except that—

"(1) coverage shall not commence unless and until—

"(A) any contribution required of the individual or family pursuant to section 2006 has been paid, and

"(B) the applicable premium has been paid by the State;

"(2) as to an individual or family eligible pursuant to subsection 2003 (a) (4) (B), coverage shall commence on the first day of the calendar month following the 2 calendar months whose wages are used as the basis of such eligibility provided application for enrollment is filed and contributions and premiums paid within 30 days of such date; and

"(3) as to an individual or family who is a Federal cash recipient, coverage shall be retroactive to the first of the month in which the individual or family became eligible as a Federal cash recipient, and the State shall pay the appropriate premiums for the period of retroactive coverage, as well as the premium for the next month, at the time application for enrollment is submitted to the administering carrier.

"INDIVIDUAL AND FAMILY CONTRIBUTIONS AND STATE PREMIUM PAYMENTS

"Individual and Family Contributions

"SEC. 2006. (a) Individuals and families enrolled in a qualified State health care plan shall be required to contribute toward the cost of the plan for any given policy year, by paying to the administering carrier, for each month for which coverage is provided, an amount limited as follows:

(1) In the case of an individual or family whose eligibility is based on having met the conditions set forth in section 2003 (a) (4) (A), the contribution for each month is one-twelfth of 10 percent of the excess of the adjusted gross income of such individual or family for the taxable year on which eligibility is based over the applicable amount specified in (g) : *Provided, however,* That the amount so determined shall be reduced (but not below zero) by the total premium, if any, paid for such month by the individual or family to the Social Security Administration for enrollment in the supplementary medical insurance program for the aged described in part B of title XVIII of the Social Security Act.

(2) In the case of an individual or family whose eligibility is based on having met the conditions set forth in section 2003 (a) (4) (B) the contribution for each month is one-half of 1 percent of the dollar limit applicable to the policy year concerned—

"(A) under 2003 (a) (4) (A) (i) for a single individual

"(B) under 2003 (a) (4) (A) (ii) for a familv of two, or

"(C) under 2003 (a) (4) (A) (iii) for a family of three or more.

(3) No contribution shall be required of an individual or family whose eligibility is based on having met the conditions set forth in section 2003 (a) (4) (C).

"State Payment of Contributions on Behalf of Certain Individuals and Families

"(b) As to any month of a policy year that an individual or family has established that he or it is a Federal cash recipient, any contribution required for that month pursuant to subsection (a) shall be paid by the State on behalf of that individual or family.

"State's Share of the Premium

"(c) Each State which has a qualified State health care plan shall pay the administering carrier an amount equal to the excess of the sum of items (1) and (3) over item (2)—

"(1) the total premium cost for the policy year,

"(2) the total amount of contributions actually paid to the administering carrier by the individuals and families as provided for in this section,

"(3) the total amount refunded pursuant to subsection (e) (5).

"Nonvariability of Contributions and Premiums

"(d) The amount of contribution and the amount of premium shall be established by family size category on the day application for enrollment was made, and shall not change as a result of a change in family size thereafter.

"Due Date of Contributions and State Premium Payments

"(e) (1) Except as otherwise provided in this subsection (e), any contribution required of an individual or family, or of the State on behalf of a Federal cash recipient, for a given month of a policy year shall be due and payable—

"(A) in advance of the first day of that month, or

"(B) in the case of the initial contribution by an individual or family whose coverage may commence retroactively to the first of the month pursuant to the exception permitted by subsection 2005 (d) (2), on the date application for enrollment is made.

"(2) As to any individual or family whose monthly contribution would, in the absence of this paragraph, be less than the administering carrier's cost of billing and collecting such contributions, the administering carrier shall require contributions to be paid quarterly, semiannually or annually in advance, whichever is necessary in order to first bring such cost below the amount of the less frequent contribution.

"(3) Any individual or family member who is required to make contributions for his coverage other than in accordance with (2) above and who is an employee (as defined in section 3121 (d) of the Internal Revenue Code of 1954) may require his employer to make periodic deductions from his wages, and remit each contribution to the administering carrier on or before the due date specified in subsection (1).

"(4) (A) At least 15 days prior to the first day of a given calendar month, the administering carrier shall estimate the excess of the total premiums due that month over the total contributions that will be paid by enrolled individuals and families that month and shall bill the State for such estimated excess. If payment by the State of any such billing is not received by the first day of the month it is due, the administering carrier shall not be liable for benefit payments thereafter.

"(B) After the end of any given policy year, the carrier shall determine the amount required to be paid by the State in accordance with subsection (c), and shall—

"(I) charge the State with any excess of the amount so determined over the total of the estimated monthly payments made by the State with respect to that policy year; or

"(II) credit the State with any excess of the total of the estimated monthly payments made by the State with respect to that policy year over the amount so determined.

Any such charge shall be paid by the State within 30 days of receipt of written notice from the administering carrier.

"(5) If at the end of any given policy year an individual or family covered for all or part of that policy year furnishes the administering carrier satisfactory evidence that his or its adjusted gross income for his or its last taxable year preceding April 1 of the calendar year in which that policy year ended was less than the applicable amount specified in (g), then the administering carrier shall refund to that individual or family the total amount of contributions he or it paid with respect to that policy year, and such refund shall be a valid charge to the State by the administering carrier.

"State Payment of Premiums for Part B Medicare Benefits

"(f) Each State which has a qualified State health care plan shall make available, and pay premiums for, supplementary medical insurance benefits under part B of title XVIII of the Social Security Act to any individual or family member who is enrolled in that State's qualified State health care plan, who is eligible for such supplementary medical insurance benefits and who either—

"(1) has established eligibility as a Federal cash recipient at the time his application for enrollment in the qualified State health care plan is made; or

"(2) had adjusted gross income for the taxable year on which eligibility is based less than the applicable amount specified in (g).

Such benefits shall be made available pursuant to an agreement entered into under section 1843 of the Social Security Act, or by reason of the payment of premiums under such title by the appropriate State agency on behalf of the individuals.

"(g) for purposes of (a) (1), (e) (5), and (f) (2) of this section and for purposes of section 280 (c) (8) (D) (ii) of the Internal Revenue Code of 1954, the applicable amount shall be 40 percent of the dollar limit applicable to the policy year concerned—

"(A) under section 2003 (a) (4) (A) (i) for a single individual,

"(B) under section 2003 (a) (4) (A) (ii) for a family of two, or

"(C) under section 2003 (a) (4) (A) (iii) for a family of three or more.

"EXTENSION AND TERMINATION OF COVERAGE

"General Rule

"Sec. 2007. (a) Except as provided in subsection (d), subject to timely payment as specified in section 2006 (e) of any contribution required under section 2006 by the individual or family and subject to timely payment of the State's share of the premium as specified in section 2006 (e), qualified State health care plan coverage shall remain in force—

"(1) with regard to an individual or family made eligible under section 2003 (a) (4) (A), for the balance of the policy year;

"(2) with regard to an individual or family made eligible under section 2003 (a) (4) (B), until the end of the calendar month following the first calendar month with respect to which the individual or family fails to furnish satisfactory evidence that his or its adjusted gross income was below the applicable amount specified in section 2003 (a) (4) (B) or the end of the policy year if earlier; and

"(3) with regard to an individual or family made eligible under section 2003 (a) (4) (C), until the end of the third calendar month following the calendar month in which eligibility for public cash assistance ceased or the end of the policy year if earlier.

"Extended Coverage

"(b) Qualified State health care plan coverage shall immediately extend to any child born to, or adopted by, any eligible family member subsequent to the day the application for enrollment was made, and shall continue in force until the date the family's coverage would otherwise terminate in accordance with this section.

"Continued Coverage

"(c) Qualified State health care plan coverage during the policy year shall not be terminated because an individual who was an eligible family member on the day the application for enrollment was made ceases to be an eligible family member subsequent to the date of application.

"Termination of Coverage

"(d) (1) Qualified State health care plan coverage shall terminate as of the first day of any calendar month if any contribution due with respect to that month has not been paid by the applicable due date specified in section 2006(e).

"(2) If qualified State health care plan coverage is terminated in accordance with paragraph (1) and a request for reinstatement is made within 30 days following the day coverage terminated, the individual or family will be extended continuous coverage upon payment of the overdue contribution and all remaining contributions due during the balance of that portion of the policy year that coverage would have remained in force pursuant to subsection (a) had timely payments been made plus a service charge of $10.

"(3) If qualified State health care plan coverage is terminated in accordance with paragraph (1) and the individual or family fails to request reinstatement as provided for in paragraph (2), the individual or family shall not be eligible for any coverage under the qualified State health care plan for the balance of the policy year concerned, and if such individual or family is eligible and desires to enroll for the next policy year, he or it must first pay a service charge of $10.

"APPROVAL OF INSTITUTIONAL RATES OF REIMBURSEMENT BY STATE HEALTH CARE INSTITUTIONS COST COMMISSIONS

"State Commission

"SEC. 2008. (a) In the operation of a qualified State health care plan no charge for services rendered or supplies furnished by hospitals, skilled nursing facilities, or home health agencies (herein collectively referred to as 'health care institutions') shall be reimbursed to the extent that such charges exceed the rates approved by a State health care institutions cost commission. Such commission shall be a State agency designated by the Governor of each State for the purpose of performing the functions described in this section. Such commission shall operate with the advice of a council appointed by the Governor. The council shall include at least two consumer representatives, one hospital representative, one skilled nursing facility representative, one home health agency representative, one hospital service organization representative, one insurance company representative, and one representative of the State health planning and development agency established pursuant to section 1521 of title XV of the Public Health Service Act. One of the representatives shall be designated as chairman of the advisory council.

"Review of Budgets and Charges

"(b) The commission shall review budgets and proposed charges for the health care institutions in the State in order to establish prospectively approved charges which shall be applicable without discrimination to all purchasers of services and supplies from health care institutions, irrespective of whether the purchasers are insured pursuant to any provision of this title and irrespective of type of underwriter which may provide insurance to a purchaser. Once each year, each health care institution shall file its budget and proposed charges with the commission. The commission may approve the use of a single charge for all of a group of services commonly rendered a class of patients or a single all-inclusive daily charge for all inpatient services of the health care institution. Filed charges shall be deemed approved unless disapproved by the commission within 60 days after filing.

"Standards for Health Care Institutions

"(c) In reviewing the proposed charges of health care institutions in the State, the commission shall require at least the following standards of each such institution—

"(1) (A) an active review committee of qualified physicians and other personnel that effectively determines whether the services rendered are—

"(i) of good quality,

"(ii) needed for the proper treatment of the patient, and

"(iii) provided only as long as necessary within the health care institution; and

"(B) management that takes effective and prompt action with respect to adverse findings;

"(2) utilization of a standard system of accounting and cost finding established by the commission;

"(3) utilization of the approved charges for all patients; and

"(4) a budget of its expenses for each fiscal year, using the approved standard system of accounting and cost finding, and charges for its services, both reasonably related to the cost of efficient production of such services.

The commission shall also take into consideration economic factors in the health care institution's geographical area, costs of comparable institutions providing comparable services, capital requirements, and the need for incentives to improve service and institute economies which might be secured from the sharing of joint services with other health care institutions.

"Amortization of Capital Costs

"(d) In reviewing that portion of a health care institution's charges which results from financing costs and depreciation relating to prior capital expenditures, the commission shall accept the determination, if any, of the appropriate health systems agency (as defined in section 1512 of the Public Health Service Act) that the construction of such facility was consistent with the health needs of the area.

"Appeal by Health Care Institution Following Disapproval by Commission

"(e) If the budget submitted by a health care institution reveals significant operating inefficiencies or if the proposed charges otherwise appear to be unjustifiably high, the commission shall disapprove the proposed charges. If the proposed charges are disapproved, the affected health care institution may request consideration of the advisory council constituted by virtue of subsection (a). Upon receipt of such request, the council shall hold a hearing at which the interested parties may appear to present the facts which support the commission's decision and the facts which support the affected health care institution's position. Following such hearing the council shall advise the commission of its recommendation, and the commission shall thereupon render a final decision.

"Federal Payment for Cost Commission's Expenses

"(f) The Secretary shall pay to any State which has a qualified State health care plan an amount equal to 75 percent of the reasonable amounts expended by the State each quarter as found necessary by the Secretary for the proper and efficient administration of the State's health care institutions cost commission and its advisory council except that there shall be no reimbursement by the Secretary for the cost of any institutional audits that may be conducted by the commission.

"REVIEW OF LEVELS OF INSTITUTIONAL RATES OF REIMBURSEMENT BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE

"Filing With the Secretary

"SEC. 2009. (a) Annually on a date specified by the Secretary, each State health care institutions cost commission shall file with the Secretary, on a form prescribed by him, a report of the level of rates of institutional reimbursement approved by the commission for such categories of health care institutions as shall be established by the Secretary. The categories shall take into consideration the type and size of the institutions and differing economic characteristics by geographic areas within each State so that each category will include institutions with similar conditions of operating cost.

"Review by the Secretary

"(b) In the event the Secretary determines that the level of rates approved for a given category of health care institution in a State is unjustifiably high in relation to those of other States, he shall order a reduction for that State in the Federal medical assistance percentage (as defined in section 1905(b) of title XIX of the Social Security Act), and a reduction in the Federal health care percentage (as defined in section 2012(d)) to compensate for the excess cost resulting from the unjustifiably high level of rates for that category of health care institutions in the State. The State may appeal the Secretary's decision, and upon receipt of an appeal, the Secretary shall appoint a hearing board of three members which shall hold a hearing at which the interested parties may appear to present the facts which support the Secretary's decision and the facts which support the appellant State's position. The members of the hearing board shall each be knowledgeable with respect to the costs of operating health care institutions of the category concerned and may not be an employee or an owner of any of the health care institutions concerned. Following such hearing the hearing board shall advise the Secretary of its recommendation, and the Secretary shall thereupon render a final decision. There shall be no further right of appeal or review by the State. If the State, whose Federal percentages have been reduced, takes action to correct the situation which produced the unjustifiably high level of rates for the category of health care institutions, it may so notify the Secretary and request restoration of the full amount of the Federal medical assistance percentage and the full amount of the Federal health care percentage. If the Secretary is satisfied that corrective action has been taken, he shall restore the Federal percentages to their full amount for that State as of the date he deems the corrective action to have eliminated the unjustifiably high level of rates.

"OPERATION OF THE QUALIFIED STATE HEALTH CARE BENEFITS POOL

"General Rule

"SEC. 2010. (a) The qualified State health care benefits pool (hereinafter in this section referred to as the 'pool') shall be administered by the administering carrier.

"Fiscal Operation

"(b) (1) The premiums collected pursuant to this title, the service charges described in section 2007 (d) and the reimbursements for pool losses described in subsection (c) (2) shall be paid into the pool.

"The pool shall be available—

"(A) without fiscal year limitation to pay all qualified State health care plan benefit claims certified by the administering carrier;

"(B) without fiscal year limitation to pay premiums to approved health maintenance organizations (as defined in section 2015 (m));

"(C) to pay the risk charges specified in section 2004 (b);

"(D) to repay to pool reinsurers the losses, if any, specified in section 2004 (b) (2) (C);

"(E) to pay the administrative charges of the administering carrier described in section 2004 (b); and

"(F) to pay any other charges for which the pool has a liability.

"(2) The moneys in the pool shall be invested and reinvested in interest-bearing obligations, which may be sold for the purpose of the pool. The interest on, and the proceeds from the sale of, such obligations become a part of the pool.

"Experience Accounting

"(c) (1) At the close of each policy year, an experience accounting for the pool for the policy year shall be prepared by the administering carrier and submitted to the Secretary, to the State, and to all reinsurers specified in section 2002 (c).

"(2) (A) All reinsurers shall participate in any pool losses in accordance with a formula, designed by the administering carrier and approved by the Insurance Commissioner, that equitably allocates pool losses to carriers and approved health maintenance organizations in proportion to their total health care business and to uninsured plans in proportion to their benefit payments under qualified employee health care plans. The aggregate pool losses for any policy year to be apportioned among the pool participants shall be limited to such percent of the qualified State health care plan premiums collected by the pool for the year as shall be mutually agreed upon from time to time by the insurance commissioner, the administering carrier, and three members of the American Academy of Actuaries with experience in health care insurance, two of whom are appointed by the Governor of the State and one by the administering carrier. Losses in excess of this limitation shall be borne by the State.

"(B) The State shall collect the uninsured plans' share of the pool losses, and remit such amount together with the State's payment for its share of the losses to the administering carrier within 45 days after the experience accounting has been submitted. The other reinsurers shall remit their share of the loss to administering carrier within 31 days after the experience accounting has been submitted.

"(3) If the experience accounting reflects a gain (computed after deduction of the reinsurers' risk charge described in section 2004(b)) for the policy year, the gain shall be retained in the pool and used to minimize future premiums to be paid by the State.

"FURNISHING OF INFORMATION BY OTHER AGENCIES

"General Rule

"Sec. 2011. (a) The head of any Federal or State agency shall furnish such information as the administering carrier needs for purposes of spot auditing eligibility for the qualified State health care plan, or verifying other information with respect thereto.

"Carrier's Liability

"(b) A reliance by the administering carrier on information furnished by any Federal or State agency shall relieve the carrier from liability for failure to charge sufficient contributions, overpayment of benefits, or any other erroneous act resulting from the carrier's reliance on such information.

"PAYMENTS TO STATES

"Premiums

"Sec. 2012. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a qualified State health care plan an amount equal to the product obtained by multiplying the total premiums for the qualified

State health care plan paid by a State to the administering carrier by the Federal health care percentage defined in subsection (d). In applying the preceding sentence, the amount used as total premiums paid by a State for a qualified State health care plan shall not include any portion thereof that is determined by the Secretary to be attributable to benefits provided under the plan which are in excess of the minimum standard health care benefits then required by section 2002 (a) to be provided.

"Pool Losses

"(b) From the sums appropriated therefor, the Secretary shall pay to each State which has a qualified State health care plan an amount equal to the product obtained by multiplying the excess pool losses paid by the State to the administering carrier (as provided by section 2010 (c) (2) (A)) by the Federal health care percentage defined in subsection (d). For the purpose of this subsection, the Federal health care percentage shall be as determined before any reduction thereof provided for under section 2004 (c) (3), or section 2009.

"Condition for Payment and Compliance

"(c) The amounts authorized to be paid a State under this title shall not be paid by the Secretary unless the State annually certifies to the Secretary, on a date or dates set by the Secretary, that—

"(1) it has established a qualified State health care plan the administering carrier of which has been approved by the Secretary;

"(2) it has authorized the insurance commissioner of that State (as defined in section 2015 (a)) to review the premium rates of the qualified State health care plan pursuant to section 2004 (c) (1);

"(3) it has authorized a State agency to enroll Federal cash recipients in the qualified State health care plan pursuant to section 2005 (c) (1);

"(4) it has authorized the State Treasurer or other appropriate official to make the payments required of the States under sections 2006, 2008, and 2010;

"(5) it has authorized a State agency to perform the functions of the State health care institution cost commission described in section 2008;

"(6) the insurance commissioner of that State is carrying out the duties with regard to protection against insolvency as prescribed by section 2016;

"(7) it has caused to be established and has implemented regulations governing the operation of a facility to make available minimum standard health care benefits to all eligible individuals, families, and groups of less than 50 employees or members to whom such benefits would not otherwise be available, such facility to be established and operated in accordance with section 2018 below;

"(8) it has not reduced the scope of its State laws concerning workmen's compensation as to types of employment covered, types of accidents or diseases covered, or types of medical expenses covered; and

"(9) it is carrying out the remaining administrative and other duties specified in title XX.

Such certification shall, after 60 days from the date of receipt by the Secretary, be deemed acceptable unless prior thereto the Secretary notifies the State, in writing, that the certification has not been accepted.

"Federal Health Care Percentage

"(d) The term 'Federal health care percentage' for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska and Hawaii); except that (1) the Federal health care percentage shall in no case be less than 70 percent or more than 90 percent, and (2) the Federal health care percentage for Puerto Rico, the Virgin Islands, and Guam shall be 70 percent. The Secretary shall promulgate the Federal health care percentage for each State as soon as possible after enactment of this title, which promulgation shall be conclusive for each of the 4 quarters in the period beginning July 1, 1977, and ending with the close of June 30, 1978. Thereafter, the Federal health care percentage for any State shall be promulgated in accordance with the provisions of section 1101 (a) (8) (B) of title XI of the Social Security Act.

"ELIGIBILITY OF THOSE NOW COVERED UNDER CERTAIN STATE OR FEDERAL PROGRAMS

"Federal Programs

"SEC. 2013. (a) Any class of individuals or families, other than employees of the Federal Government and their families, whose members at the time of enactment of this Act, are receiving all, or substantially all, of their medical care under a Federal program, other than a program pursuant to the Social Security Act, shall not be eligible for coverage under a qualified State health care plan unless—

"(1) all members of the class who are resident in the State are enrolled in the plan;

"(2) the Federal Government pays the premium for supplementary medical insurance benefits under part B of title XVIII of the Social Security Act for all such members of the class as are eligible therefor;

"(3) the Federal Government arranges for the enrollment of such individuals and families in the qualified

State health care plan and pays the full premium therefor on behalf of such persons without requiring any sharing by the State; and

"(4) the Federal Government agrees to pay the State that proportion of any excess pool losses, charged to the State pursuant to section 2010(c)(2)(A), which the average number of such persons enrolled in such plan during the policy year bears to the average number of all persons enrolled in such plan during that year. In applying section 2012(b), the amount of such payment shall reduce the excess pool losses to which the Federal health care percentage would otherwise be applied.

"State Programs

"(b) Any class of individuals or families, other than employees of a State or local government and their families, whose members, at the time of enactment of this Act, are receiving all, or substantially all, of their medical care under a State program of medical care, other than a program pursuant to the Social Security Act, and who are not otherwise eligible for enrollment in the qualified State health care plan, shall be eligible for coverage in a qualified State health care plan provided—

"(1) all members of the class who are resident in the State are enrolled in the plan;

"(2) the State pays the premium for supplementary medical insurance under part B of title XVIII of the Social Security Act for all such members of the class as are eligible therefor;

"(3) the State arranges for the enrollment of such individuals and families in the qualified State health care plan and pays the full premium therefor on behalf of all such persons; and

"(4) the State agrees to absorb, without any sharing by the Federal Government, that proportion of the excess pool losses, charged to it pursuant to section 2010 (c) (2) (A), which the average number of such persons enrolled in such plan during the policy year bears to the average number of all persons enrolled in such plan during that year. In applying section 2012 (b), such amount shall reduce the excess pool losses to which the Federal health care percentage would otherwise be applied.

"Premium Taxes

"Sec. 2014. In order to be eligible for Federal appropriations pursuant to this title, a State (or any political subdivision thereof) —

"(1) may not impose any tax of any kind on or with respect to any premium, benefit, income, or other transaction or occurrence connected with any qualified State health care plan, qualified State health care benefits pool, or underwriting and reinsurance facility provided for under this title, and

"(2) may not impose any tax or fee on any domestic carrier which provides health care insurance in the State with respect to any premium or other income received or any benefit provided, or on any other transaction or occurrence, in connection with any health care insurance contract, unless any such tax or fee is applied equally to all domestic carriers which provide health care insurance in the State.

"DEFINITIONS

"SEC. 2015. As used in this title the term—

"(a) 'Insurance commissioner' means the public official charged with the regulation of insurance in each State.

"(b) 'Secretary' means the Secretary of Health, Education, and Welfare.

"(c) 'State' shall include each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

"(d) 'Administering carrier' means either—

"(1) a carrier licensed to issue health care insurance in each of the 50 States and the District of Columbia,

"(2) a carrier licensed to issue health care insurance in at least one of the 50 States or the District of Columbia which has one or more affiliates or wholly owned subsidiaries licensed to issue health care insurance, if in each of the 50 States and the District of Columbia the carrier or at least one of its affiliates or wholly owned subsidiaries is licensed to issue health care insurance, or

"(3) a domestic carrier, or an assemblage of domestic carriers operating as one administering unit, which the insurance commissioner of the State finds will perform its obligations as administering carrier efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

"(e) 'Underwriter' means a carrier, an approved health maintenance organization, or the person who provides an uninsured plan.

"(f) 'Policy year' means a period beginning any July 1 and ending the close of the following June 30.

"(g) 'Carrier' means an insurance company, hospital service or hospital expense indemnity organization, a medical service or medical expense indemnity organization, dental service or dental expense indemnity organization, fraternal benefit society or other similar organization or society which provides coverage for one or more types of health care.

"(h) 'Uninsured plan' means a plan provided by a person (other than a carrier or an approved health maintenance organization) having an arrangement which has been communicated or described in writing to covered individuals, and which covers at least 26 individuals for at least 26 weeks of the calendar year, and which provides, pays for, or reimburses the whole or any part of the cost of the health care of such individuals, but shall not include the Federal Government with respect to programs established by it.

"(i) 'Federal cash recipient' means an individual or family who has established eligibility for public cash assistance under a program financed in whole or in part by Federal funds.

"(j) 'Adjusted gross income' shall have the meaning set forth by section 62 of the Internal Revenue Code of 1954.

"(k) 'State of domicile' means the State in which an underwriter, other than an insurance company, maintains its principal place of business. For an insurance company which is an underwriter, 'State of domicile' means the State in which it is incorporated.

"(l) 'Family' means an individual and his spouse if not legally separated under a decree of divorce or of separate maintenance and each of their dependent (as defined in the introductory clause of section 152 (a) of the Internal Revenue Code of 1954) unmarried children who have not attained the age of 19.

"(m) 'Approved health maintenance organization' means an organization which meets the definition of a qualified health maintenance organization contained in section 1310(d) of the Public Health Service Act or which has been licensed or certified as a health maintenance organization pursuant to the applicable statute of the State in which such organization is located.

"PROTECTION AGAINST INSOLVENCY

"Definitions

"SEC. 2016. (a) As used in this section, the term—

"(1) 'NHI' means pertaining to one or more qualified health care plans (as defined in section 220(f)(6) of the Internal Revenue Code of 1954).

"(2) 'Premium' means the premium, enrollment fee, or such other comparable fee or periodic charge of an underwriter for NHI coverage.

"Capital and Surplus Requirements

"(b) An NHI underwriter shall have a combined capital and surplus of not less than the greater of: (i) $1,500,000, or (ii) 2 percent of the gross premium income of the underwriter for its immediately preceding fiscal year of operation. In lieu of holding such capital and surplus, an underwriter may, subject to the approval of the insurance commissioner of the State of domicile, either secure a performance bond issued by a company licensed to issue such bonds in the underwriter's State of domicile in an amount that is the greater of: (i) $1,500,000 or (ii) 2 percent of the gross premium income of the underwriter for its immediately preceding fiscal year of operation; or, secure a written contract, from one or more carriers authorized to write NHI contracts in such State and having at least $15,000,000 of unassigned surplus, which provides that the contracting party will, in the event that, and as of the date that, such underwriter ceases to be authorized to provide NHI coverage, provide without qualification NHI coverage for all individuals or families so affected.

"Reserve Requirements

"(c) Each NHI underwriter shall—

"(1) Maintain NHI reserves in an amount not less on any day than—

"(A) the total amount of its liability for unearned premiums, future contingent benefits, and amounts not yet due on claims,

"(B) the total amount of its liability for due and unpaid claims, claims in course of settlement, and incurred but unreported claims, and

"(C) 12½ percent of the total amount of its NHI claims paid during the preceding calendar year but not more than $25,000,000, which amount shall be called the NHI Contingency Reserve (hereinafter 'NHICR') and may be maintained either directly or as a portion of the underwriter's surplus: *Provided, however,* That such 12½ percent requirement shall be applied to the total amount of an approved health maintenance organization's premium during the preceding calendar year. The underwriter may, subject to the approval of the insurance commissioner of its State of domicile, credit against its NHICR the value of those of its contracts with providers of health services as guarantee the delivery of the contracted services even in the event of insolvency of the underwriter.

"(2) Maintain NHI reserves, including the NHICR, in assets qualified as legal investments for life insurance companies of the same size by the laws of the State of domicile.

"(3) Submit an affidavit, executed by its chief executive officer or by a member of the American Academy of Actuaries or another actuary approved by the insurance commissioner of the State of domicile, to such insurance commissioner within 90 days after the end of each calendar year that its NHI reserves comply with the requirements of this section. Such affidavit shall be accompanied by a financial report for the prior calendar year on a form prescribed by the insurance commissioner describing its NHI business including but not limited to—

"(A) information substantiating the adequacy of its NHI reserves;

"(B) disclosure of the manner in which its NHICR was computed;

"(C) balance sheet; and

"(D) income statement.

"(4) Submit an affidavit to the insurance commissioner of each State in which the underwriter does NHI business within 90 days after the end of each calendar year showing the amount of NHI premiums paid for lives in that State during such calendar year. For an uninsured plan, such NHI premiums shall be the greater of:

"(A) the deduction for a taxable year under section 162, 212, or 404 of the Internal Revenue Code of 1954 claimed by a person having such arrangement with respect to benefits provided under NHI coverage plus the amount of any contributions collected from its members for NHI coverage with respect to the year concerned, or

"(B) 105 percent of NHI claims paid by the uninsured plan during the calendar year.

"State Supervision

"(d) An underwriter not otherwise subject to the supervision of its business by the insurance commissioner of its State of domicile shall, as a condition to providing NHI coverage, file with that insurance commissioner a notarized affidavit agreeing to subject its NHI business to his supervision and to pay any assessments duly levied pursuant to this subtitle D.

"Procedure To Prevent Impairment

"(e) (1) Any NHI underwriter whose NHICR fails to meet the requirements of this section shall be impaired for purposes of this title and promptly shall—

"(A) cease issuance of any new group or individual NHI policies: *Provided, however,* That such NHI underwriter may continue to issue coverage under an existing group plan; and

"(B) provide the insurance commissioner of the underwriter's State of domicile with:

"(i) an appraisal by a member of the American Academy of Actuaries or an actuary provided by the insurance commissioner of the capacity of the underwriter to pay claims on its outstanding NHI coverage; and "(ii) either a plan for reinsurance of its NHI obligations with an NHI carrier, or a plan for reconstituting its NHICR.

"(C) advise the obligor under the performance bond, if such bond was purchased pursuant to subsection (b), of the NHI underwriter's possible financial inability to meet its obligations under this Act.

"(2) An insurance commissioner, upon receipt of such information, shall—

"(A) determine whether the proposed reinsurance carrier has NHI reserves adequate to comply with this section after accepting the proposed reinsurance and, if he approves the proposed plan for reinsurance, notify the impaired underwriter to execute such plan within 60 days. If the plan for reinsurance is not approved, the insurance commissioner shall notify the impaired underwriter that the plan for reinsurance has not been approved and that a plan for reconstituting its NHICR must be submitted within 30 days; and

"(B) if an impaired underwriter submits a plan for reconstituting its NHICR, appoint a committee to supervise the reconstitution of the NHICR. The committee shall be chaired by the insurance commissioner of the impaired underwriter's State of domicile. The members of the committee shall include the insurance commissioner of the impaired underwriter's State of domicile, a representative of the insurance commission of one of the States in each National Association of Insurance Commissioners zone in which the impaired underwriter issued NHI coverage and at least one officer from five NHI carriers other than the impaired underwriter.

"(3) The committee's responsibilities shall include—

"(A) approval or disapproval of the impaired underwriter's plan for reconstituting its NHICR;

"(B) if such plan is approved, the committee shall provide the insurance commissioner with periodic reports concerning the execution of such plan and the need for any additional protection for NHI policyholders, members, or participants of the impaired underwriter; and

"(C) if the plan for reconstituting the impaired underwriter's NHICR is disapproved, the committee shall determine whether an assessment is necessary to meet the impaired underwriter's NHI obligations.

"(4) If the committee determines that an assessment is necessary, it shall be made according to the following formula where NHI premiums are net after reinsurance:

"(A) the total assessment shall be allocated among the States in which the impaired underwriter issued NHI coverage in proportion to the ratio of the impaired underwriter's NHI premiums paid in the State to the total of its NHI premium paid in all States for the last completed calendar year; and

"(B) a State's share of the assessment, as determined in subsection (A), shall be allocated among NHI underwriters in that State in proportion to the ratio of each underwriter's NHI premiums paid in that State for the last completed calendar year to the total NHI premiums paid in that State for that year by all NHI underwriters other than the impaired underwriter: *Provided*, That if the impaired underwriter is an insurance company, then the portion of a State's assessment that would be so charged to Blue Cross plans and Blue Shield plans shall instead be assessed on the remaining insurance companies which are NHI underwriters in proportion to their shares of that State's assessment, and if the impaired underwriter is a Blue Cross plan or a Blue Shield plan, then the portion of a State's assessment that would be so charged to insurance companies shall instead be assessed on the remaining Blue Cross plans and Blue Shield plans which are NHI underwriters in proportion to their shares of such assessment.

"(5) The insurance commissioner of each State in which the impaired underwriter did NHI business shall furnish NHI underwriters in the State with—

"(A) a copy of the committee's report;

"(B) the total amount of the assessment upon all NHI underwriters;

"(C) the underwriter's share of the assessment produced under the formula; and

"(D) a demand that payment of the assessment be made within 3 months, or such longer period of time as the insurance commissioner may authorize if such payment would, in the opinion of the committee, endanger the ability of the assessed underwriter to fulfill its contractual obligations.

"(6) Failure to make timely payment of the assessment shall be cause for withdrawal of the underwriter's privilege to conduct NHI business.

"(7) Any assessment made upon and paid by an NHI underwriter under this section shall be deductible from any other assessment made under a State insolvency law or other requirement which relates to the NHI underwriter which was deemed impaired pursuant to this section.

"REGULATIONS

"SEC. 2017. Any regulations promulgated by the Secretary with regard to this title shall be promulgated in final form not less than 9 months prior to the first day of the policy year during which they will apply. Such regulations shall be effective only if (i) promulgated in final form within the time prescribed in the preceding sentence, and

(ii) notice of such regulation in proposed form and of opportunity for public hearing thereon shall have been published not less than 60 days prior to the date of promulgation thereof in final form.

"UNDERWRITING AND REINSURANCE FACILITIES

"SEC. 2018. PRINCIPLES OF OPERATION OF THE UNDERWRITING AND REINSURANCE FACILITIES TO ASSURE AVAILABILITY OF MINIMUM STANDARD HEALTH CARE BENEFITS TO THE UNINSURABLE.—(a) The State insurance commissioner shall be responsible for assuring the establishment and regulation of a facility to underwrite or reinsure minimum standard health care benefits for individuals, families, and groups of less than 50 employees or members to whom such benefits would not otherwise be available. He shall name an administering carrier as defined in section 2015 to operate the facility.

"(b) (1) If the State has established by law a duty upon carriers to offer a qualified health care plan to all individuals and groups, then the facility shall reinsure contracts for a qualified health care plan issued by carriers and may, at the option of the State, also issue its own contracts providing a qualified health care plan, upon request by a carrier.

"(2) If the State has established no such duty upon carriers, then the facility shall issue its own contracts to provide a qualified health care plan and may, at the option of the State, also reinsure contracts providing a qualified health care plan issued by carriers.

"(3) The facility shall design only one form of qualified individual health care plan and one form of qualified employee health care plan, each providing no more and no less than the minimum standard health care benefits specified in section 220 of the Internal Revenue Code of 1954. No plan other than the one individual and one employee health care plan designed by the facility shall be issued or reinsured by the facility.

"(c) The effective date of any coverage issued or reinsured by the facility shall be the first day of the month following the month in which application was made except that when application is made within 31 days of cessation of prior qualified health care coverage the effective date shall be the day following the date of such cessation of coverage.

"(d) Any coverage issued or reinsured by the facility shall provide that during the first 6 months of coverage, benefits will not be paid on account of any condition that had been diagnosed or treated within the 6 months preceding the date of application for coverage. However, time covered under a qualified health care plan immediately preceding application shall be counted in determining whether six months of coverage have elapsed.

"(e) If State law provides or if subsection (b) above requires that the facility issue its own contracts for qualified health care benefits, then

"(1) every individual—

"(A) who is a resident of the State;

"(B) who is not eligible to enroll (through either spouse in the case of a family) in a qualified employee health care plan (as described in section 280(b) of the Internal Revenue Code of 1954);

"(C) who is not eligible to enroll in the insurance program described in part B of title XVIII of the Social Security Act; and

"(D) who is not eligible to enroll in a qualified State health care plan because he fails to meet any of the conditions specified in section 2003(a)(4); and

"(2) every group—

"(A) which is a valid group for the purposes of obtaining group health care insurance under the laws of the State, and

"(B) which contains fewer than 50 employees or members, and

"(C)(1) all of whose members reside in the State, or

"(2) in the case of an employee group, has its principal place of employment located within the State

shall, in accordance with and subject to the other provisions of this title, be eligible to apply for a qualified health care plan from the facility.

"(f) If State law provides or if subsection (b) above requires that the facility reinsure contracts for qualified health care plans issued by carriers, then only such contracts as have been issued to eligible individuals and groups as defined in subsection (e) above shall be eligible for reinsurance in the facility.

"(g) The State insurance commissioner shall appoint a committee of five actuaries who are members of the American Academy of Actuaries and who have experience in the field of health care insurance. The duties of this committee shall include the determination of expense allowances to carriers for reinsured risks, claim reserve formulas, and other actuarial functions, as well as the recommendation of premium rates for the facility. In recommending premium rates, the committee shall take into consideration the additional morbidity expected on contracts issued or reinsured by the facility, anticipated administrative expenses of the facility, reasonable expense allowances to ceding carriers, and the level of rates charged by carriers to standard risks for coverage similar to that embodied in the health care plan designed by the facility.

"(h) Following the close of each fiscal year of the facility, the administering carrier shall determine—

"(i) with respect to contracts issued by the facility—

"(A) earned premiums less allowable expenses of the facility and,

"(B) incurred losses for the year.

"(ii) with respect to contracts reinsured by the facility—

"(A) earned premiums less administrative expense allowances to carriers,

"(B) the expenses of the administering carrier pertaining to the reinsurance operations of the facility and,

"(C) incurred losses for the year.

Any excess of items (i) (B), (ii) (B), and (ii) (C) over (i) (A) and (ii) (A) shall be assessed against all underwriters in proportion to their share of the total NHI premium paid in the calendar year during which the fiscal year of the facility began. Any excess of items (i) (A) and (ii) (A) over (i) (B), (ii) (B), and (ii) (C) shall be held at interest by the administering carrier to offset future losses or to reduce future premiums. For uninsured plans, the term 'NHI premiums' shall have the meaning specified in section 2016 (c) (4)."

SEC. 532. CARRIER COMPLIANCE.

Nothing contained in antitrust legislation enacted by the Congress of the United States or by the legislatures of one or more of the several States shall be construed as limiting or in any other way applying to carriers in any activity undertaken in compliance with or in any effort to comply with any provision of this Act.

SEC. 533. CONFORMING AMENDMENTS TO TITLE XVIII OF THE SOCIAL SECURITY ACT.

Title XVIII of the Social Security Act is amended—

(1) by adding after section 1837 (g) the following new subsection:

"(h) Notwithstanding the provisions or limitations of subsections (a), (b), (c), (d), (e), and (f), there shall be a general enrollment period during the month of April in each year for individuals who was enrolling for the first time in a qualified State health care plan described in title XX of the Social Security Act."; and

(2) by adding after section 1843 (h) the following new subsection:

"(i) The Secretary shall, at the request of a State, enter into a modification of an agreement entered into with such

State pursuant to subsection (a) under which the covered group described in subsection (b) and specified in such agreement is broadened to include individuals who are described in section 2006 (f) of title XX of the Social Security Act."

SEC. 534. CONFORMING AMENDMENTS TO TITLE XIX OF THE SOCIAL SECURITY ACT.

Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"EXCLUSION FROM COVERAGE

"SEC. 1908. Notwithstanding any other provision of this title, no payment under this title may be made (a) for any expenses incurred for services or articles (1) which are covered under a qualified State health care plan (as defined in title XX), (2) which are incurred after July 1, 1977, and would have been covered under a qualified State health care plan had the State adopted such a plan, or (b) for any copayment required under a qualified State health care plan."

SEC. 535. CONFORMING AMENDMENTS REGARDING "REASONABLE COSTS".

Wherever reference is made in titles V, XVIII, and XIX of the Social Security Act to making payments to a provider on the basis of "reasonable costs" or "reasonable charges", with regard to any amount paid after June 30, 1977, that payment shall not be considered reasonable to the extent that it exceeds the amount which would be determined to be reasonable and necessary under section 2002 (e) (1) of title XX of the Social Security Act.

SEC. 536. CONFORMING AMENDMENTS TO THE INTERNAL REVENUE CODE.

(a) Section 115 (a) of the Internal Revenue Code of 1954 is amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or" and by adding after paragraph (2) the following paragraph:

"(3) interest, or any other item of income, derived from any investment by a qualified State health care benefits pool (as defined in section 2010 of title XX of the Social Security Act) or by an underwriting and reinsurance facility (as defined in section 2018 of title XX of the Social Security Act).".

(b) Section 501 (c) (8) of the Internal Revenue Code of 1954 is amended by the addition of the following item:

"(C) For purposes of this section, payments made directly or indirectly to a qualified State health care benefits pool (as defined in section 2010 of title XX of the Social Security Act) or to an underwriting and reinsurance facility (as defined in section 2018 of title XX of the Social Security Act) by a fraternal beneficiary society, order, or association under provisions of the National Health Care

Act shall not in any way disqualify such group from its tax-exempt status under this section.".

SEC. 537. EFFECTIVE DATE.

The amendments made by this subtitle shall become effective on the date of enactment of this Act, except that a qualified State health care plan provided for under new title XX of the Social Security Act shall not provide benefits before July 1, 1977.

94th CONGRESS
1st Session

H. R. 6222

IN THE HOUSE OF REPRESENTATIVES

April 22, 1975

Mr. Fulton (for himself, Mr. Carter, Mr. Duncan of Tennessee, and Mr. Murphy of New York) introduced the following bill; which was referred to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To establish a program of comprehensive medical, hospital, and dental care as protection against the cost of ordinary and catastrophic illness by requiring employers to make insurance available to each employee and his family, by Federal financing of insurance for persons of low income, in whole or in part according to ability to pay, and by assuring the availability of insurance to all persons regardless of medical history, and on a guaranteed renewable basis.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Health Care Insurance Act of 1975".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds—

(1) that the resources of many individuals are inadequate to meet the expenses of illness;

(2) that health care should be provided through a program incorporating a pluralistic system of health care delivery, and thereby sustain incentives of competition which inure to the lowering of health care costs, the introduction of innovations in the delivery of health care, and the maintenance of quality health care;

(3) that private health insurance coverage is an appropriate mechanism for insuring against the expenses of illness and fostering the development of a pluralistic health care system;

(4) that such coverage for all persons is a desirable national objective;

(5) that it is in the public interest to assure such coverage to employees and their families through employment and to provide Government assistance and encouragement to other individuals who seek the protection of insurance against the expense of illness; and

(6) that health insurance should be made available to all residents regardless of previous medical history.

(b) The purpose of this Act is to establish a national health care insurance program that will provide comprehensive benefits, including institutional, medical, dental, and other health care, protecting against ordinary and catastrophic expenses of illness for all individuals under which program—

(1) employers would be required to make available and contribute toward the cost of comprehensive health care insurance for their employees and their families;

(2) the Federal Government would pay, in whole or in part, on a basis scaled to individual and family incomes, the cost of comprehensive health care insurance for those unable to pay for their own, with such participation being provided through issuance of certificates of entitlement or allowances of credits against income tax; and

(3) the availability of comprehensive health care insurance would be assured to all persons regardless of prior medical history and on a guaranteed renewable basis.

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COMPREHENSIVE HEALTH CARE INSURANCE ACT OF 1975

Part A—Health Care Insurance for Employees

INSURANCE REQUIREMENT

Sec. 3. (a) (1) Every employer shall, under the terms and conditions hereinafter stated, offer to each of his employees qualified health care insurance for the employee and the members of his family. Such insurance shall be offered as a policy, plan, or contract provided or offered by a qualified carrier, or as a health plan duly sponsored or underwritten by such employer or an employee organization, which provides the benefits and meets the other requirements described in part C.

(2) In addition to meeting the requirements of paragraph (1), every employer shall provide for continuation of such insurance of an employee and the members of his family following termination of his employment as may be required by section 46.

(b) Coverage of an employee and his family under this section shall be optional to the employee. Election of coverage by the employee must be made within the thirty-day period following the date of his employment or during any open enrollment period thereafter, except as otherwise provided in section 46 (insurance for the unemployed) when such coverage is needed as a replacement of insurance furnished through another member of the family whose employment has been terminated.

(c) For the purpose of this section—

(1) An employer shall be an individual, corporation, firm, or agency, including Federal, State, and local governments and their agencies and instrumentalities, that employs at least one employee.

(2) An employee shall be an individual who is

currently employed and has been employed by an employer for more than thirty days and either—

(A) is considered to be a full-time employee; or

(B) is not considered to be a full-time employee, but is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months; or

(C) is not considered to be a full-time employee but has actually worked at least twenty hours a week for at least twenty-six weeks during the previous twelve months,

and shall include employees of the Federal, State, and local governments, and their agencies and instrumentalities, but shall not include any individual by virtue of military service.

(3) A family shall be—

(a) a husband and wife (not divorced or legally separated), or

(B) such spouses and dependent unmarried children under nineteen (under twenty-three in the case of a full-time student), or

(C) an individual and his or her dependent unmarried children under nineteen (under twenty-three in the case of a full-time student), and the words "dependent" and "children" shall have the same meaning as when used in sections 151 and 152 of the Internal Revenue Code.

COMMUNICATION TO EMPLOYEES

SEC. 4. (a) In offering qualified health care insurance to employees pursuant to section 3 (a), the employer shall at the time of employment advise such employees of their entitlement to obtain such coverage and the benefits provided thereunder, the manner in which coverage shall be obtained, the applicable premium, and the employer share and (if any) the employee share of the premium.

(b) No employer shall offer financial inducement for, or make acceptance of or continued employment contingent upon, either acceptance or rejection of coverage under this part.

CONTRIBUTIONS TO PREMIUM

SEC. 5. (a) When qualified health care insurance is made available to an employee pursuant to section 3 and the employee elects to obtain such coverage, the employer shall contribute to the cost of such coverage for the benefit of the employee and his family at least 65 per centum of the premium; the employee shall contribute the balance. The premium shall be paid for the period of the employment and, provided the employee continues to pay his share of the premium, for thirty days following termination of the employment relationship or until such time, if sooner, as the employee has obtained coverage in new employment or under the provisions for insurance for the unemployed in section 46 of this Act.

(b) An employee may elect, at his own expense to continue his qualified health care insurance under this part, for a period of sixty days after expiration of the thirty-day period following his termination of employment, and, if he has received health insurance coverage as an unemployed person pursuant to section 46 of this Act, for sixty days following expiration of the period of such coverage.

CREDITS AGAINST TAX FOR LOW-INCOME EMPLOYEES

Sec. 6. (a) An employee whose share of the premium for qualified health care insurance for himself and the members of his family under this part exceeds the amount of premium, if any, that he would be required to pay for such insurance if he were eligible and insured therefor under part B (plan for the nonemployed and the self-employed), shall be entitled to a certificate of entitlement in the amount of such excess or a credit against tax with respect to the amount of such excess which he has paid.

(b) An individual and the members of his family who are eligible for benefits under this part shall be ineligible for benefits under part B (plan for the nonemployed and the self-employed).

PENALTIES FOR NONCOMPLIANCE

SEC. 7. (a) The Attorney General of the United States may bring suit to compel an employer to comply with the provisions of this part. Such a suit may be brought in a United States district court for the district in which the employer's principal place of business is located.

(b) An employee may bring suit to compel his employer to comply with the provisions of this part for the benefit of such employee and to reimburse any amounts such employee or members of his family spent for health care services which would have been available to them under qualified health care insurance during the period such employer was in noncompliance. Such suit may be brought, without regard to jurisdictional amount, in the United States district court for the district in which the plaintiff's place of employment is located or such other district as may be permitted by law.

(c) An employer who willfully and knowingly fails to offer qualified health care insurance to employees as required under section 3 may be assessed a civil penalty of not more than two times the amount such employer would have spent in compliance.

EMPLOYER SUBSIDIES

SEC. 8. (a) Employers experiencing substantial increases in payroll cost within the meaning of subsection (b) as a result of the obligation under section 3 to make qualified health care insurance available to employees and their families will be entitled to cash payment by the Secretary or a credit against income tax. Such subsidy will be provided during a five-year transition period beginning with the first year in which the requirement of employers to contribute to premium for such insurance becomes effective. Payroll cost for the purposes of this section shall consist of payroll items which are of a type normally subject to social security tax withholding (regardless of amount) and the cost to the employer of health care insurance for his employees and their families. Tax credit unused in one year may be applied against income tax liability for the five succeeding years following the year in which such tax credit was earned.

(b) The amount of subsidy shall be a portion of the amount by which the added payroll cost resulting from compliance with section 3 increases the total payroll cost of the employer in an amount in excess of 3 per centum of such total payroll cost. In the first year in which the requirements under section 3 become effective, the subsidy shall be 80 per centum of such excess; and the rate of subsidy shall be reduced to 70 per centum in the second year, 60 per centum in the third year, 50 per centum in the fourth year, and 40 per centum in the fifth year.

(c) The Secretary of Health, Education, and Welfare shall conduct a continuing study of the effect upon employers, particularly upon small employers, of the requirement in this part for employers to make qualified health care insurance available to their employees and their families and to contribute to the premium on such insurance. Such study shall give consideration to the need for continuation or modification of the employer subsidy, the period of such subsidy, and alternative methods of providing such subsidy if needed. The Secretary shall publish the findings on such study within one year after enactment of this part and from time to time thereafter, but at least annually.

(d) There are authorized to be appropriated such sums as may be necessary for the Secretary of Health, Education, and Welfare to make payments required by this section.

PREMIUM FOR EMPLOYEE GROUP PLANS

SEC. 9. (a) Premiums for employee groups of one to one hundred persons and self-employed persons shall not exceed 125 per centum of the estimated average in the State of annual premium for employee groups of more than one hundred persons.

(b) Each insurance company or other such organization which develops and offers qualified health care insurance plans to any employers to whom section 3 is applicable must develop (itself or in combination with other such carriers or other organizations) a health care plan or plans to which employers with one hundred employees or less may subscribe.

EFFECTIVE DATE FOR EMPLOYER PLAN

SEC. 10. Every employer covered under this part shall provide qualified health care insurance to his employees and the members of their families as required under section 3 beginning on the first day of the second calendar year following the date of enactment.

PART B—PLAN FOR THE NONEMPLOYED AND SELF-EMPLOYED

ESTABLISHMENT OF THE BENEFIT PROGRAM

SEC. 21. (a) There is hereby established a program of Federal participation, through a system of certificates of entitlement issued by the Secretary and credits against income tax, in the premium for qualified health care insurance providing comprehensive hospital, medical, dental, and other health care services for individuals and families who are not eligible for coverage under part A—the plan for employees and their families. This shall cover nonemployed and self-employed individuals and their families.

(b) The amount of Federal participation in premiums under this section shall be related to income of the individual or family, the Government to pay the full premium for those whose annual incomes are insufficient to create income tax liability, and to pay a gradually smaller proportion of the premium for others in relation to increasing amounts of income tax liability, as provided in section 23.

(c) For the purposes of this part, a family shall be—

(1) a husband and wife (not legally separated or divorced), or

(2) such spouses and their dependent unmarried children under nineteen (under twenty-three in the case of a full-time student), or

(3) an individual and his or her dependent unmarried children under nineteen (under twenty-three in the case of a full-time student),

and the terms "dependent" and "children" shall have the same meaning as when used in sections 151 and 152 of the Internal Revenue Code.

(d) When used in this part, "Secretary" shall mean the Secretary of Health, Education, and Welfare.

ELIGIBILITY

SEC. 22. (a) Federal participation in health care insurance premium is provided for nonemployed or self-employed individuals and their families who are residents of the United States and are ineligible for qualified health care insurance under part A of this Act, and shall apply with respect to—

(1) qualified health care insurance purchased by or for persons who are under the age of sixty-five and not

eligible for benefits under part A of title XVIII of the Social Security Act, and

(2) qualified supplemental insurance purchased by or for persons who have reached the age of sixty-five or are otherwise eligible for benefits under part A or B of title XVIII of the Social Security Act.

(b) To be entitled to benefits under this part, an individual eligible for such benefits must apply for insurance provided in paragraph (1) or (2) in subsection (a) within sixty days after the date on which Federal participation under this section shall become effective, or within sixty days of becoming otherwise eligible, or during any open enrollment period thereafter.

TAX CREDITS AND CERTIFICATES OF ENTITLEMENT

SEC. 23. Any individual or family entitled to Federal participation in premium under this part may claim such benefit—

(1) by application to the Secretary directly, or through a qualified insurance carrier or its agent, for a health care insurance certificate of entitlement acceptable by any qualified carrier for payment of premium for qualified health care insurance (or qualified supplemental insurance), or

(2) as a credit against income tax liability under the Internal Revenue Code with respect to premium paid for qualified health care insurance (or qualified supplemental insurance).

COMPUTATION OF PREMIUM PARTICIPATION

SEC. 24. (a) The value to be assigned to the certificate of entitlement or the amount of credit against tax under this part shall be based on taxable income (as measured by income tax liability), subject to any adjustment for special income under subsection (b), during the base year of the individual or family; and such certificate or credit shall be claimed with respect to qualified health care insurance for the benefit year. For this purpose, the base year of an eligible individual or family shall be any taxable year beginning after the year of enactment of this Act; the benefit year shall be any twelve-month period beginning in the year immediately following the close of the base year.

(1) If an individual or family incurs no income tax liability for a base year, such individual or family shall be eligible for a certificate of entitlement or a credit against

income tax for 100 per centum of the premium for qualified health care insurance (or qualified supplemental insurance) for the benefit year following.

(2) If an individual or family has been receiving qualified health care insurance under section 46 (insurance for the unemployed), such individual or family shall be eligible under this part for a certificate of entitlement or a credit against income tax for 100 per centum of premium for qualified health care insurance for the remainder of the calendar year in which the entitlement to such insurance under section 46 expires, or until such time, if sooner, as such individual or family becomes eligible for coverage under part A.

(3) If an individual or family incurs income tax liability in a base year, the amount of the certificate of entitlement or the allowable credit against tax for the benefit year shall be determined by multiplying the amount of the premium for qualified health care insurance (or qualified supplemental insurance) by the applicable percentage factor in the following scale:

PERCENTAGE OF PREMIUM ALLOWABLE UNDER SECTION 24(a)

Income tax liability in base year	Percentage factor
$0	100
$1 to $10	99
$11 to $20	98
$21 to $30	97
$31 to $40	96
$41 to $50	95
$51 to $60	94
$61 to $70	93
$71 to $80	92
$81 to $90	91
$91 to $100	90
$101 to $110	89
$111 to $120	88
$121 to $130	87
$131 to $140	86
$141 to $150	85
$151 to $160	84
$161 to $170	83
$171 to $180	82
$181 to $190	81
$191 to $200	80
$201 to $210	79
$211 to $220	78
$221 to $230	77
$231 to $240	76
$241 to $250	75
$251 to $260	74
$261 to $270	73
$271 to $280	72
$281 to $290	71
$291 to $300	70
$301 to $310	69
$311 to $320	68
$321 to $330	67
$331 to $340	66
$341 to $350	65
$351 to $360	64
$361 to $370	63
$371 to $380	62
$381 to $390	61
$391 to $400	60
$401 to $410	59
$411 to $420	58
$421 to $430	57
$431 to $440	56
$441 to $450	55
$451 to $460	54
$461 to $470	53
$471 to $480	52
$481 to $490	51
$491 to $500	50
$501 to $510	49
$511 to $520	48
$521 to $530	47
$531 to $540	46
$541 to $550	45
$551 to $560	44
$561 to $570	43
$571 to $580	42
$581 to $590	41
$591 to $600	40
$601 to $610	39
$611 to $620	38
$621 to $630	37
$631 to $640	36
$641 to $650	35
$651 to $660	34
$661 to $670	33
$671 to $680	32
$681 to $690	31
$691 to $700	30
$701 to $710	29
$711 to $720	28
$721 to $730	27
$731 to $740	26
$741 to $750	25
$751 to $760	24
$761 to $770	23
$771 to $780	22
$781 to $790	21
$791 to $800	20
$801 to $810	19
$811 to $820	18
$821 to $830	17
$831 to $840	16
$841 to $850	15
$851 to $860	14
$861 to $870	13
$871 to $880	12
$881 to $890	11
$891 or over	10

(b) (1) The percentage of premium allowable as a credit against tax or in the determination of the amount of the certificate of entitlement under subsection (a) shall be adjusted with respect to any special income of the individual or family. For this purpose the percentage factor shall be reduced by 1 percentage point for each full hundred dollars of special income, if any, of such individual or family, except that in no case shall the allowable credit be reduced to less than 10 per centum of premium.

(2) Special income for the purposes of paragraph (1) shall be income of the individual or family which is not subject to tax under the Internal Revenue Code, except that pension or annuity payments or social security payments (or a combination thereof) shall be included only to the extent that the amount thereof exceeds $4,000 in any taxable year.

(c) If an individual or family makes an overpayment to a carrier by certificate of entitlement and any other form of payment, such overpayment shall be recoverable by the eligible individual or family from the carrier.

(d) If an individual's or family's credit against tax under this section should exceed his income tax liability for the taxable year in which such credit is applicable, such individual or family may claim such excess as though it were made an overpayment of income tax.

CERTIFICATE OF ENTITLEMENT

SEC. 25. (a) A health insurance certificate of entitlement shall be a certificate issued by the Secretary to an individual or family, or to a carrier on behalf of such individual or family, which may be applied toward payment of premium on a qualified health care insurance (or qualified supplemental insurance) policy or plan, which may be redeemed only as provided in subsection (c).

(b) Any individual eligible for a health insurance certificate of entitlement and electing such certificate in lieu of an income tax credit shall make application therefor. Such application shall contain such information as the Secretary may by regulations prescribe, including—

(1) the name, address, date of birth, social security number, marital status of the applicant and of the spouse of the applicant, if any;

(2) the name, address, date of birth, social security number, marital status, and relationship to the applicant of each of the dependents of the applicant for whom coverage is claimed;

(3) any taxable income, special income, and Federal income tax liability of the applicant, his spouse, and the dependents named in the application for the base year, and the place where each filed his last income tax return.

(c) The Secretary shall issue regulations which shall provide for the redemption of health insurance certificates of entitlement which have been certified to have been accepted by an insurance carrier in full or part payment for a qualified health care insurance (or qualified supplemental insurance) policy or plan.

PREMIUM ON PLANS FOR THE NONEMPLOYED AND OTHERS

SEC. 26. (a) The premium rate to be charged for a qualified health care insurance policy offered under this part for any year shall in no case exceed 125 per centum of the estimated average of premiums paid in the State for qualified health care insurance for groups of employees with more than one hundred members.

(b) Each insurance company or other such organization which develops and offers qualified health care insurance plans under part A shall develop (itself or in combination with other such carriers or other organizations) qualified health care insurance (and qualified supplemental insurance) policies and plans for purchase by individuals and families eligible for such coverage under this part.

EFFECTIVE DATE FOR FEDERAL PARTICIPATION

SEC. 27. Federal participation in premium under this part shall become effective for benefit years beginning on and after the first day of the second calendar year following enactment.

PART C—QUALIFIED HEALTH CARE INSURANCE

QUALIFIED INSURANCE DEFINED

SEC. 31. (a) "Qualified health care insurance" shall be a health care insurance policy, plan, or contract provided or offered by a qualified carrier (as defined in section 33) which provides comprehensive hospital, medical, dental, and other health care benefits (including protection against the catastrophic expenses of illness) for any individual or member of a family, and which satisfies all other conditions and requirements set forth in the following sections.

(b) "Qualified supplemental insurance" shall be a health care policy, plan, or contract providing the same coverage and conditions and requirements as qualified health care insurance, except that—

(1) coverage under qualified supplemental insurance shall exclude all items and services to the extent that they are included as benefits in parts A and B of title XVIII of the Social Security Act, and shall not reimburse for deductibles and coinsurance imposed under that title; and

(2) benefits provided under qualified supplemental

insurance shall not be subject to any deductible or coinsurance.

COVERAGE

Benefits

SEC. 32. (a) Qualified health care insurance shall provide as a minimum, subject to the exclusions, coinsurance, and other provisions of this section, for payment during any policy year for the following benefits for each individual—

(1) inpatient care in a hospital for three hundred and sixty five days;

(2) one hundred days of inpatient care in a skilled nursing facility;

(3) any emergency or outpatient services customarily provided by a hospital on an outpatient basis;

(4) any medical care provided by or under the direction of a doctor of medicine or a doctor of osteopathy, including diagnostic, therapeutic, and preventive medical services (as well as emergency or other outpatient services), regardless of where such services are provided;

(5) all home health services during the policy or plan period provided to an individual under the care of a physician in the place of residence used as such individual's home;

(6) dental care provided by a doctor of dentistry

for diagnosis, therapy, and treatment of children from two through six years of age; and emergency dental services and oral surgery for all persons: *Provided, however,* That one year after the effective date for dental care under this Act, the maximum age at which children shall be entitled to dental care as provided in this subsection shall be increased to include children through age seven, and such maximum age shall be further increased by one additional year at the beginning of each succeeding calendar year until dental care so provided shall be made available to all children who have not reached eighteen years of age at the commencement of coverage under a policy or plan under this Act; and

(7) medically necessary ambulance service.

Exclusions

(b) No payment may be made under this title for any of the expenses incurred for health care services—

(1) which are not preventive or reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(2) for which the individual furnished such items has no legal obligation to pay, and which no other person (by reason of such individual's membership in a

prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act);

(4) for which payment is or will be made with respect to such items or services, under a workmen's compensation law or plan of the United States or a State;

(5) which constitute personal comfort items;

(6) where such expenses are for custodial care;

(7) where such expenses are for eyeglasses, hearing aids, or orthopedic shoes;

(8) where such services are for cosmetic surgery or are incurred in connection therewith, except as required for repair of accidental injury or for improvement of the functioning of a malformed body member;

(9) where such expenses are for—

(A) private room accommodations provided during inpatient hospital confinement unless such accommodations are medically necessary; or

(B) private duty nursing.

Coinsurance Requirement

(c) A qualified health care insurance policy, plan, or contract shall, within the limits prescribed in subsection (d), require coinsurance of 20 per centum with respect to all items and services covered hereunder, except that no such coinsurance shall apply to any individual or family eligible for full subsidy of premium under section 24 (a) (1) or (2).

Protection Against Catastrophic Expense

(d) (1) As protection against catastrophic expense of illness, the cumulative amount of coinsurance for any individual or family in any policy year shall not exceed—

(A) 10 per centum of the difference between the annual income of the individual or family and the coinsurance deduction (as defined in paragraph (2)), or, if less,

(B) $1,500 for any individual or $2,000 for any family.

(2) For the purposes of paragraph (1), the coinsurance deduction shall be—

(i) in the case of any individual, $1,500,

(ii) in the case of any family with two members, $3,000,

(iii) in the case of any family with three members, $3,600,

(iv) in the case of any family with four members, $4,200, and

(v) in the case of any family with five or more members, $4,800.

Other Requirements of Qualified Health Care Insurance

(e) In addition to the benefit requirements in subsection (a) a qualified health care insurance policy, plan or contract must provide—

(1) that the insurance will not be cancelable by the carrier; will guarantee renewal, and will contain no exclusions based on preexisting conditions;

(2) that benefits under all qualified health care insurance (and qualified supplemental insurance) under this Act will be coordinated in order to avoid duplication of benefits or payment of coinsurance;

(3) that payment for physician services will be made at usual and customary or reasonable charges for all services covered;

(4) that payment for hospital services will be determined by appropriate State agencies, after consultation with providers of such services and organizations of such providers, under acceptable methods of reimbursement including appropriate prospective rate determination systems, which include, without being limited to, budget review, negotiated rates, target rates, or formula negotiation;

(5) that other costs shall be paid on a reasonable charge or a reasonable cost basis, as appropriate.

Hospital, Medical, Dental and Other Health Care Services Defined

(f) The following definitions apply to the benefit requirements set out in subsection (e)—

(1) "inpatient care in a hospital" shall mean all inpatient services customarily furnished and charged for by a hospital, including a general, psychiatric, and tuberculosis hospital, including (but not limited to)—

(A) bed and board and nursing services,

(B) drugs, oxygen, blood and plasma (except for the first three pints furnished in the twelve-month policy period), biologicals, supplies, appliances, and equipment furnished by and used in the hospital,

(C) use of the hospital facilities ordinarily furnished for the care and treatment of inpatients, including (but not limited to) the surgery or delivery room, recovery room, intensive care units, coronary care units, rehabilitation care units, special care units, and supplies,

(D) care for pregnancy or any of its complications, and

(E) psychiatric care;

(2) "inpatient care in a skilled nursing facility" shall mean all inpatient services customarily furnished

and charged for by a skilled nursing facility, including (but not limited to)—

(A) bed and board and skilled nursing services,

(B) physical, occupational, or speech therapy, and

(C) such drugs, biologicals, supplies, appliances, and equipment furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(3) "emergency and outpatient services" shall mean services in addition to physicians' or dentists' services provided on an outpatient basis and separately itemized, including (but not limited to)—

(A) outpatient diagnostic services, such as X-rays, electrocardiograms, laboratory tests, and other recognized medical or dental diagnostic tests,

(B) use of operating, cystoscopic, and cast rooms and their supplies, and

(C) use of emergency room and supplies when needed for medical, dental and surgical emergencies;

(4) "medical care" shall mean all medical services (including diagnostic, therapeutic, and preventive) provided by or under the direction of a doctor of medicine or a doctor of osteopathy, licensed to practice medicine

or osteopathy, regardless of where such services are provided, including (but not limited to)—

(A) diagnosis or treatment of illness or injury,

(B) psychiatric care,

(C) well-baby care,

(D) inoculations and immunizations of infants and adults against communicable diseases,

(E) physical examinations,

(F) diagnostic X-ray and laboratory services,

(G) radiation therapy,

(H) consultation,

(I) services for pregnancy and complications of pregnancy, including prenatal, obstetrical, and post partum care, and

(J) anesthesiology services.

(5) "home health services" shall mean services furnished through a certified home health agency to an individual who is homebound under the care of a doctor of medicine or osteopathy under a plan established and periodically reviewed by a physician, which items and services are provided on a visiting basis in a place of residence used as such individual's home, including—

(A) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse,

(B) physical, occupational, or speech therapy and

(C) medical supplies (other than drugs and biologicals), and the use of medical appliances while under such a plan.

(6) "dental care" shall mean all services prescribed by a doctor of dentistry as preventive, diagnostic, therapeutic, restorative, rehabilitative, and emergency services, excluding, however, orthodontics and cosmetic surgery, except when furnished in connection with covered dental services. Emergency dental service shall mean the control of bleeding in life-hazardous oral conditions, relief of severe pain through immediate palliative treatment only, treatment of injuries to the teeth and supporting tissue, and initial treatment for elimination of major acute infection of the oral cavity. Oral surgery shall mean surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw.

QUALIFIED CARRIERS

SEC. 33. A qualified carrier may be a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of health services under individual or group insurance policies, plans, or contracts, or similar arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefit plan duly sponsored or underwritten by an employee organization, which—

(1) is authorized by the appropriate State agency to operate as a carrier of health insurance in its State,

(2) provides or proposes to provide qualified health care insurance (or qualified supplemental insurance) for persons eligible therefor under parts A and B of this Act,

(3) agrees to participate in any assigned risk pool which is authorized by the State pursuant to section 44;

(4) provides at least two thirty-day enrollment periods in each year, not more than six months apart, for the purchase of qualified health care insurance (or qualified supplemental insurance), except, however, that an individual or family already covered by qualified health care insurance (or qualified supplemental insurance) shall be entitled to purchase new insurance to provide for continuation of such coverage without waiting for an open enrollment period,

(5) provides for audit procedures to identify expenditures for services furnished under this program

according to the various classes of health care providers,

(6) agrees to provide assistance to individuals in the preparation and filing of applications for certificates of entitlement under this Act, and, on the basis of any application duly prepared and filed, to place insurance promptly in effect pending receipt or rejection of the certificate of entitlement: *Provided, however,* That the Secretary shall guarantee payment of premium for such period of coverage pending issuance or rejection of the certificate, and

(7) assures appropriate procedures for the protection of confidentiality of medical records of patients.

PART D—MISCELLANEOUS

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

SEC. 41. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the practice of dentistry or the manner in which dental services are provided, or over the selection, tenure, or compensation of any officer or employee or any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

FEDERAL HEALTH INSURANCE REDEMPTION FUND

SEC. 42. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Federal Health Insurance Redemption Fund (hereinafter referred to as the "fund"). The fund shall consist of such amounts as may be deposited in or appropriated to it as provided in subsection (b).

(b) There is authorized to be appropriated to the fund from time to time, out of moneys in the Treasury not otherwise appropriated, an amount equal to the aggregate amount of premiums paid under this Act through the redemption of health insurance certificates, issued pursuant to sections 6 and 23, and such portions of premium as may be required to cover the guarantee of premium pursuant to section 33 (6). Sums authorized and appropriated pursuant to this section shall be considered premiums payable and deposited in such fund. Certificates shall upon presentation to the Secretary of Health, Education, and Welfare be redeemed through payments from the fund.

PUBLIC INFORMATION

SEC. 43. The Secretary shall provide for a continuing program of public education on the importance and need for individual and family protection against the expenses of illness and the provision by this Act for health care insurance of individuals and families through employment and for Federal assistance to the nonemployed and the self-employed in obtaining such protection, using such methods of communication, including the development and dissemination of information through schools, public agencies, public and private organizations, and carriers, as he deems appropriate.

ASSIGNED RISK POOLS

SEC. 44. A carrier offering a qualified health care insurance policy in any State shall participate in an assigned-risk pool which may be established in such State by the State insurance department or by such agency as may be authorized by the State. The carrier shall accept from the pool such risks under this program as may be assigned to it. A State shall establish such a pool only if the commissioner of insurance (or other appropriate official) in that State determines that such a pool is necessary to making qualified health care insurance available to all persons desiring to purchase such insurance.

ESTABLISHMENT OF HEALTH INSURANCE ADVISORY BOARD

SEC. 45. (a) There is hereby created a Health Insurance Advisory Board (hereinafter referred to as the "Board") which shall consist of fifteen persons, including the Secretary of Health, Education, and Welfare and the Commissioner of Internal Revenue. The remaining members, not otherwise in the employ of the United States, shall be appointed by the

President, with the advice and consent of the Senate, without regard to the provisions of title 5, United States Code, governing appointment in the competitive service. The Secretary of Health, Education, and Welfare shall serve as Chairman. The appointed members of the Board shall be selected from persons who are specifically qualified to serve on such Board by virtue of their education, training, or experience, and shall include at least six persons who are practicing doctors of medicine, one practicing doctor of osteopathy, and one practicing doctor of dentistry recommended by the appropriate national professional organizations, and each of whom shall be licensed in a State as a doctor of medicine, osteopathy, or dentistry; and the remaining members of the Board shall be members of the general public. Each of the appointed members shall be appointed for a term of four years except that, when appointments are first made, four shall be appointed for terms of two years, four for terms of three years, and five for terms of four years, and except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. The Secretary of Health, Education, and Welfare may appoint such special advisory professional or technical personnel or committees as may be needed to carry out the purposes of this title. Members of the Board and other personnel or members of any advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Board or of a committee, shall be entitled to receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding $200 per day, including traveltime, and while so serving away from their business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Board shall meet as frequently as the Chairman deems necessary but not less than twice annually. Upon request of four or more members, it shall be the duty of the Chairman to call a meeting of the Board.

Duties of Advisory Board

(b) The Health Insurance Advisory Board shall—

(1) prescribe such regulations as may be necessary to carry out the purposes and provisions of this title;

(2) establish minimum Federal standards for the use of State insurance departments in determining whether an insurance company and plan are qualified under this title;

(3) in consultation with carriers, providers of services, and consumers, plan, review, and develop, where necessary programs whose purposes are to provide for maintaining the quality of medical care, and the effective

utilization of available financial resources, health manpower, and facilities, through utilization review, peer review, and other means which provide for the participation of the insurance carriers and the providers of services;

(4) review the effectiveness of the program established in this Act, and especially the utilization review procedures developed by the carriers and the several professional associations, and file, by December 31 of each year, with the President and the Congress and annual report—

(A) on the operation and status of the program during the past fiscal year and on its expected operation during the current and next two succeeding fiscal years, with

(B) any recommendations for changes in the law designed to improve the effectiveness of the program.

The Board is authorized to request from any department, agency (or independent instrumentality of the Government), any information it determines is necessary to carry out its functions under this title, and each such department, agency, or independent instrumentality is authorized to cooperate with the Board and, to the extent permitted by law, to furnish such information to the Board upon request made by the Chairman.

INSURANCE FOR THE UNEMPLOYED

SEC. 46. (a) Each individual who is receiving benefits under a Federal or State unemployment compensation law, and who upon termination of his last employment was covered by qualified health care insurance pursuant to section 3 of this Act, shall (except as otherwise provided in this section) with the members of his family be entitled to qualified health care insurance for the unemployed as provided in subsection (b) : *Provided, however,* That if an individual or member of his family is covered or is eligible for coverage pursuant to section 3 of this Act through an employed member of his family, such individual or members of his family shall not be entitled to coverage under this section: *Provided further,* That any employee who would be entitled to coverage through his employer under section 3 may elect immediate coverage under that section, without waiting for the next open enrollment period, when such coverage is needed to continue family coverage theretofore provided through another member of that family whose employment has been terminated.

(b) With respect to any individual eligible under subsection (a) for insurance for the temporarily unemployed, the Secretary of Health, Education, and Welfare shall pay the full premium for continuation of his qualified health care insurance furnished through his employer and in effect at the time his employment was terminated. Such premium shall be paid to the appropriate carrier, or as reimbursement to the employer, for a period commencing with the expiration of the employer's obligation under that Act to provide and contribute to the premium on insurance for such employee and ending with the effective date for the insurance coverage of such employee and his family in newly obtained employment, except that such period shall not extend beyond thirty days following the date on which such employee's entitlement to unemployment compensation is exhausted.

(c) Application for benefits under this section shall be made within thirty days following termination of the employment, and the initial certification shall be effective to provide for coverage commencing on the date of termination of the employment or, if later, the date of expiration of coverage of the employee and his family by insurance under the employer's health insurance program. Any certification of eligibility shall be effective for a period of four weeks, and the agency shall from time to time review and recertify any individual's eligibility in order to provide for continuation of coverage for the period during which he is unemployed and eligible for compensation benefits.

(d) The Secretary shall enter into agreements with the

State agency administering benefits under the unemployment compensation laws to make determinations of eligibility for insurance under this section and to certify to employers and carriers the entitlement of any individual to such insurance. The agreement shall provide for payment by the Secretary to the State agency of the reasonable expenses incurred by the agency in performing such functions.

(e) There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the requirements of this section.

INCOME TAX AMENDMENTS

SEC. 47. (a) Part IV of subchapter A of chapter 1 of subtitle A of the Internal Revenue Code of 1954 (relating to credits against tax) is amended by redesignating section 42 as section 43; and by inserting after section 41 the following section:

"HEALTH CARE INSURANCE PREMIUMS

"SEC. 42. There shall be allowed as a credit against tax imposed by this subtitle amounts allowed as credits under sections 6 and 23 of the Comprehensive Health Care Insurance Act of 1975 with respect to premiums paid for qualified health care insurance or qualified supplemental insurance.".

(b) Part VI of subchapter B of chapter I of subtitle A of the Internal Revenue Code is amended by changing the designation "Sec. 220" to "Sec. 221" and adding after section 219 the following new section:

"Sec. 220. There shall be allowed as a business deduction by any person who is self-employed and who contributes to premium for qualified health care insurance for one or more employees, pursuant to the requirement in section 3 of the Comprehensive Health Care Insurance Act of 1975, an amount equal to 65 percent of premium paid by him in purchasing qualified health care insurance for himself and his family: *Provided, however,* That the amount so deducted shall not be claimed also as a medical expense deduction under section 213 or as a basis for credit against income tax or certificate of entitlement under the Comprehensive Health Care Insurance Act of 1975.

(c) Part VII of subchapter B of chapter 1 of subtitle A of the Internal Revenue Code of 1954 is hereby amended by adding a new subsection (g) to section 213, as follows:

"(g) If an individual elects to take the credit against tax provided in section 42 for any taxable year with respect to premiums paid in such year for a qualified health care insurance policy or plan, such premiums paid shall not be a basis for deduction under this section.".

LIMITATION ON CIVIL LIABILITY

Sec. 48. The civil liability of any health care practitioner or provider of health care services to any person under any law of the United States or of any State or political subdivision thereof, in any action for damages for injury or death arising out of care or treatment for which payment may be made (in whole or in part) under this Act or under the Social Security Act shall not include costs incurred or anticipated for health care services for which any payment may be made under this Act. Moreover, such costs shall in no case be recoverable as damages in any action brought more than one year after the date on which the claimant knew or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of such dates occurs first, nor in any event if such action is brought more than four years after the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death.

94TH CONGRESS
1ST SESSION

H. R. 6283

IN THE HOUSE OF REPRESENTATIVES

APRIL 22, 1975

MR. YOUNG of Georgia introduced the following bill; which was referred to the Committees on Ways and Means and Interstate and Foreign Commerce

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A BILL

To amend the Social Security Act to establish a national health care program for all Americans under which all existing health care programs for the aged and poor are consolidated, to provide for the administration of the national health care program and the existing social security programs by a newly established independent Social Security Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, divided into titles and sections according to the following table of contents, may be cited as the "Comprehensive National Health Care Act of 1975".

VI—O

TABLE OF CONTENTS

Sec. 1. Short title; table of contents.
Sec. 2. Findings and declaration of purpose.

TITLE I—NATIONAL HEALTH CARE PROGRAM

Sec. 101. Establishment of program.

"TITLE XVIII—NATIONAL HEALTH CARE PROGRAM

"Sec. 1801. Short title.
"Sec. 1802. Free choice by patient and practitioner.
"Sec. 1803. Administration of program.

"PART A—SCOPE OF BENEFITS

"Sec. 1811. Benefits provided.
"Sec. 1812. Payment for outpatient drugs and biologicals.

"PART B—ELIGIBILITY FOR BENEFITS

"Sec. 1821. Eligible individuals.

"PART C—METHOD OF PAYMENT TO ELIGIBLE INDIVIDUALS

"Sec. 1831. Establishment of individual accounts.
"Sec. 1832. Payment for items and services.

"PART D—ADMINISTRATION OF PROGRAM

"Sec. 1841. Conditions of and limitations on payment.
"Sec. 1842. Payment to providers of services; prospective determination of payment to providers; quality management payments.
"Sec. 1843. Agreements with providers of services.
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"Sec. 1858. Designation of organization or publication by name.

"Sec. 1859. Penalties.
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TITLE II—INDEPENDENT SOCIAL SECURITY ADMINISTRATION

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Sec. 203. Transitional provisions.
Sec. 204. Miscellaneous and conforming amendments.
Sec. 205. Miscellaneous and conforming amendments.
Sec. 206. Miscellaneous and conforming amendments.
Sec. 207. Effective data.

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Sec. 302. Planning by health care providers and conditions for payment.
Sec. 303. Technical and conforming amendments.
Sec. 304. Additional technical and conforming amendments.
Sec. 305. Effective date.

FINDINGS AND DECLARATION OF PURPOSE

Sec. 2. (a) The Congress finds that—

(1) the health of the Nation's people is the foundation of their well-being and of our Nation's strength, productivity, and wealth;

(2) adequate health care for all of our people must now be recognized as a right, regardless of a person's race, creed, color, sex, or wealth; and

(3) a system of national health care is the means to implement that right.

(b) The purpose of this Act is—

(1) to create a system of national health care benefits which will make comprehensive health services available to all residents of the United States;

(2) through the operation of the system, to effect modifications in the organization and methods of delivery of health services which will increase the availability and continuity of care, will enhance its quality, will emphasize the maintenance of health as well as the treatment of illness and, by improving the efficiency and the utilization of services and by strengthening professional and financial controls will restrain the mounting cost of care while providing fair and reasonable compensation to those who furnish it;

(3) through financing programs of health resource development based on National, State, and areawide planning; to assure that the amounts and kinds of personnel, facilities, and services needed to obtain health care covered by this Act are actually available in every community; and

(4) through an independent contributory, social insurance program which administers funds placed in trust by all Americans, to assure a stable and systematically managed program which responds to the needs of both its beneficiaries and those who provide health care services in the Nation.

TITLE I—NATIONAL HEALTH CARE PROGRAM

ESTABLISHMENT OF PROGRAM

Sec. 101. The Social Security Act is amended by striking out title XVIII and inserting in lieu thereof the following new title:

"TITLE XVIII—NATIONAL HEALTH CARE PROGRAM

"SHORT TITLE

"Sec. 1801. This title may be cited as the 'National Health Care Program'.

"FREE CHOICE BY PATIENT AND PRACTITIONER

"Sec. 1802. The administration of this title shall not interfere with the freedom of every physician and every patient to choose where and how they will give or receive health care. Neither the Board of the Social Security Administration, nor any of its agents, shall make medical judgments with respect to a patient's health care; this function is reserved solely to the physician and his or her peers.

"ADMINISTRATION OF PROGRAM

"SEC. 1803. (a) Except as otherwise provided in this title, the national health care program established by this title shall be administered by the Board of the Social Security Administration established by section 701 (hereinafter in this title referred to as the 'Administration'). The Administration may perform any of its functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Administration may deem necessary.

"(b) The Administration may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of its functions under this title.

"(c) In the course of any hearing, investigation, or other proceeding that it is authorized to conduct under this title, the Administration may administer oaths and affirmations.

"PART A—SCOPE OF BENEFITS

"BENEFITS PROVIDED

"Covered Services

"SEC. 1811. (a) (1) Eligibility of an individual for health care benefits under the program established by this title consists of entitlement to have payment made on behalf of such individual in accordance with the provisions of this title for the following items and services:

"(A) inpatient hospital services;

"(B) physicians' services;

"(C) medical and other health services;

"(D) home health services;

"(E) post-hospital extended care services;

"(F) outpatient drugs and biologicals;

"(G) routine dental services;

"(H) developmental vision care services, as defined in regulations, routine eye and vision examinations, and eyeglasses;

"(I) hearing aids and examinations therefor; and

"(J) routine physical examinations and preventive services as defined in regulations.

The items and services described in the preceding sentence include items and services related to mental health care, including those furnished in cases of alcoholism and drug abuse.

"(2) Notwithstanding the provisions of paragraph (1), payment under the program will not be made for items and services—

"(A) which are not reasonable and necessary for the diagnosis, treatment, or prevention of congenital defect, illness, or injury or to improve the functioning of a malformed body member; except that nothing in this subparagraph shall prevent payment under the program for family planning and prenatal care items and services, routine dental services, routine eye and vision examinations, and examinations for hearing aids;

"(B) for which the individual furnished such items or services has no legal obligation to pay and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(C) which are not provided within the United States, except as provided under the terms of a treaty within the United States and the nation within which such services are provided;

"(D) which constitute personal comfort items;

"(E) which constitute custodial care;

"(F) which constitute cosmetic surgery or are provided in connection therewith; except as required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member;

"(G) which are provided by immediate relatives of the individual or members of his or her household;

"(H) which are kidney dialysis or transplantation items and services, unless provided by a kidney dialysis or transplantation center or facility which meets such requirements as the Administration may by regulation provide; or

"(I) to the extent that payment has been made, or can reasonably be expected to be made, with respect to those items and services, under a workmen's compensation law or plan of the United States or a State (and any payment under the program shall be conditioned on reimbursement to the Federal Health Care Trust Fund when notice or other information is received that payment for the items or services involved has been made under such a law or plan).

"Coverage Limits

"(b) Payment under the program for—

"(1) posthospital extended care services shall be limited to one hundred and eighty days per calendar year;

"(2) home health care services shall be limited to one hundred and eighty visits per calendar year;

"(3) inpatient psychiatric hospital services shall be limited to forty-five days of active treatment per calendar year and partial hospitalization for the treatment of mental illness, as defined in regulations prescribed by the Administration, shall be limited to ninety days per calendar year; and

"(4) services provided on an outpatient basis for the treatment of mental illness in any calendar year shall be limited to the estimated cost of fifty outpatient visits to a private practitioner for the treatment of mental illness, as determined by the Administration in November of the preceding year, and payment for such services other than services provided on an outpatient basis in a comprehensive community care center, as defined in regulations, shall be limited to two-thirds of that amount.

"Review of Services

"(e) For requirement that Professional Standards Review Organizations review services for which payment is or may be made under this title, see section 1155(h) (as amended by section 104 of the Comprehensive National Health Care Act of 1975).

"PAYMENT FOR OUTPATIENT DRUGS AND BIOLOGICALS

"SEC. 1812. The amount paid to any participating pharmacy which is a provider of services with respect to outpatient drugs and biologicals for which payment may be made under this title shall, in accordance with section 1847, be the reasonable allowance with respect to such drugs and biologicals.

"PART B—ELIGIBILITY FOR BENEFITS

"ELIGIBLE INDIVIDUALS

"SEC. 1821. (a) Every individual, without regard to race, sex, income, or age, who is a resident of the United States shall be eligible for health care benefits under and in accordance with this title. In addition, an individual may be eligible for such benefits as provided in subsection (b).

"(b) Any individual who is a resident of a nation with which the United States has in effect a treaty providing for the reciprocal payment of health care benefits shall be eligible for health care benefits under and in accordance with this title during such time as the individual is physically located in the United States.

"PART C—METHOD OF PAYMENT TO ELIGIBLE INDIVIDUALS

"ESTABLISHMENT OF INDIVIDUAL ACCOUNTS

"SEC. 1831. (a) In order to provide for the payment on behalf of eligible individuals of the amounts due under this title for items and services furnished them, the Social Security Administration shall establish for each eligible individual an account against which such individual may charge the cost of obtaining any items and services furnished him or her under this title.

"(b) Payment for any items and services furnished an eligible individual under this title (other than emergency services) shall be made only on the basis of charges against such individual's account, except that payment for any items and services furnished an eligible individual under this title, when such eligible is an infant or child under the age of eighteen years for whom no account has yet been established, shall be made on the basis of charges against the account of either (but not both) parent of such individual.

"PAYMENT FOR ITEMS AND SERVICES

"Sec. 1832. Payment for items and services furnished an eligible individual shall be made by the Social Security Administration (at the applicable reimbursement rates) to the providers of services and other persons by which or by whom such items and services were furnished, on the basis of charges against such individual's account established under section 1831, in accordance with section 1842 in the case of providers of services and section 1846 in the case of other persons (including physicians).

"Part D—Administration of Program

"CONDITIONS OF AND LIMITATIONS ON PAYMENT

"Requirement of Requests and Certifications

"Sec. 1841. (a) Except as provided in (c), (g), and (h) of this section and in section 1845, payment for items and services furnished an individual may be made only to providers of services which are therefor under section 1843 and only if—

"(1) written request, signed by such individual, except in cases in which the Social Security Administration finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Administration may by regulation prescribe, no later than the close of the period of two calendar years following the year in which such services are furnished (deeming any services furnished in the last three calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Administration deems that efficient so requires, such period may be reduced to not less than one calendar year;

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the fifteenth day of such period) that—

"(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

"(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment as or could be reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

"(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he or she receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1851 (b)), prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

"(D) in the case of home health services (i) such services are or were required because the individual is or was confined to his or her home (except when receiving items and services referred to in section 1851 (m) (7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (ii) such services are or were furnished while the individual is or was under the care of a physician;

"(E) in the case of medical and other health services except services described in subparagraphs

(B), (C), and (D), of section 1851 (g) (2), such services are or were medically required;

"(F) in the case of outpatient physical therapy services (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; or

"(G) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

"(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the fifteenth day of such period;

"(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he or she was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

"(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he or she was receiving treatment which could reasonably be expected to (A) improve his or her condition or (B) render it noncommunicable;

"(6) with respect to inpatient hospital services furnished such individual after the fifteenth day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1843 (d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility);

"(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the members of the committee or group, as described in section 1851 (k) (4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further posthospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the fourth day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; and

"(8) with respect to outpatient drugs or biologicals, the participating pharmacy (as defined in section 1851 (bb)) has the physician's prescription in its possession, or some other record (in the case of insulin) that is satisfactory to the Administration.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), (E), (F), or (G) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term 'provider of services' shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1851 (o) (4) (A), or if, in the case of a public health agency, such agency meets the requirements of section 1851 (o) (4) (B), but only with respect to the furnishing of outpatient physical therapy services as therein defined.

"No Payments to Federal Providers of Services

"(b) No payment may be made under this title (except under subsection (c)) to any Federal provider of services or other Federal agency, except a provider of services which the Administration determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"Payment for Emergency Hospital Services

"(c) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements (as defined in section 1851 (y)) with it, to an individual entitled to benefits under this title if (A) such services were emergency services, (B) the Administration would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payment for all such inpatient emergency services and for the emergency outpatient services referred to in subsection (k) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1843 (a).

"(2) Payment may be made on the basis of an itemized bill to an individual entitled to benefits under this title for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as shall be prescribed in regulations) for reimbursement.

"(3) The amounts payable under the preceding paragraphs with respect to services described therein shall be equal to 80 percent of the hospital's reasonable charge for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations, whichever is less, plus 90 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on three-fourths of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term 'routine services' shall mean the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made; the term 'ancillary services' shall mean those special services for which charges are customarily made in addition to routine services.

"Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

"(d) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Administration) for such services which are furnished to the individual prior to notification to such hospital from the Administration of his or her lack of entitlement, if such payments are precluded only by reason of section 1811(b) and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed: *Provided*, That—

"(1) such hospital has an agreement with the Administration under section 1843, and

"(2) the Administration has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes, and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

"Payment for Posthospital Extended Care Services

"(e) (1) An individual shall be presumed to require the care specified in subsection (a) (2) (C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1811 (b)) for posthospital extended care services which are furnished by such facility to such individual if—

"(A) the certification referred to in subsection (a) (2) (C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

"(B) such certification states that the medical condition of the individual is a condition designated in regulations,

"(C) such certification is accompanied by a plan of treatment for providing such services, and

"(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions to the individual as may be prescribed in regulations, taking into account the medical severity of such conditions, the degree of incapacity, the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Administration deems pertinent.

"(2) If the Administration determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions desgnated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).

"Limitation on Payment for Outpatient Drugs and Biologicals

"(g) Payment may be made under this title for outpatient drugs and biologicals only when they are dispensed by a participating pharmacy; except that payment under this title may be made for outpatient drugs and biologicals dispensed by a physician where the Administration determines, in accordance with regulations, that such drugs and biologicals were required in an emergency or that there was no participating pharmacy available in the community, in which case the physician (under regulations) shall be regarded as a participating pharmacy for purposes of this title with respect to the dispensing of such drugs and biologicals.

"Limitations on Payment for Surgery and Other Specialized Services

"(h) (1) Payment may be made under this title for major surgery or for other specialized services designated in regulations only when they are furnished by specialists and, to the extent specified in regulations, are either emergency services or services furnished on referral by a physician engaged in general or family practice (as determined in accordance with regulations).

"(2) A physician is a specialist, for purposes of paragraph (1), only if he or she holds a certificate from the appropriate national speciality board; except that (A) a physician who possesses the qualifications requisite to such certification may furnish services as a specialist during a period of five years after attaining such qualifications and (if later) a period of five years after the effective date of health benefits under the program, (B) a physician may be authorized by the Administration to furnish services as a specialist if (i) prior to such effective date he or she has engaged in furnishing such services as a specialist or as a substantial part of his or her medical practice, (ii) he or she meets standards established by the Administration, and (iii) where appropriate, authorization to him or her to furnish services as a specialist is recommended by a participating hospital in which he or she has engaged substantially in furnishing such services, and (C) a physician may be authorized by the Administration to furnish services as a specialist if the number of physicians with the same speciality in the geographic area involved (as established under section 1511 of the Public Health Service Act) is insufficient to meet the needs of the residents of such area.

"(3) The Administration may by regulations exclude from covered services specified surgical procedures, when not required by life-threatening or other acute emergencies, which have not been preceded by consultation with, and recommendation of surgery by, such appropriately qualified specialists as may be required by the regulations. Hospital and other services incident to surgery excluded by regulations under this subsection are not covered services.

"(4) The Administration may by regulation reduce payments for specialized procedures where there is determined to exist an overabundance of specialists in the same procedure within the geographic area involved (as established under section 1511 of the Public Health Service Act) sufficient to meet the needs of the residents of such area.

"(5) With respect to the performance of surgical procedures specified in regulations under paragraph (3), including emergency procedures, the Administration may require as a condition of payment to the provider that there be submitted to the Administration or the carrier having responsibility for the administration of noninstitutional benefits under this title in the area involved pursuant to section 1845 a pathology report on tissue removed and a clinical abstract or discharge report of the case.

"Limitation on Payment for Practitioner Services Furnished in Nonparticipating Hospital

"(i) Payment may not be made under this title for services furnished by a professional practitioner in a hospital which is not a participating provider of services.

"Limitation on Payment for Certain Prosthetic Devices

"(j) Payment may not be made under this title—

"(1) for a fixed dental prosthesis without approval in advance given by the Professional Standards Review Organization for the area involved (or, if there is no such organization for that area, in such manner and by such entity as the Board may determine); or

"(2) for a hearing aid without a prescription therefor written by a physician.

"Payment for Certain Outpatient Services Furnished by Nonparticipating Hospital

"(k) (1) Payment may also be made to any hospital for services described in section 1851(g) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this title even though such hospital does not have an agreement in effect under this title, if (A) such services were emergency services, (B) the Administration would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to subsection (c) (1) (C), with respect to the calendar year, in which such emergency services are provided. Such payments shall be made only if such hospital agrees to comply, with respect to the provisions of section 1843 (a).

"(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph solely because the hospital does not elect, in accordance with subsection (c) (1) (C), to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information, as the Administration shall by regulations prescribe) for reimbursement.

"PAYMENT TO PROVIDERS OF SERVICES; PROSPECTIVE DETERMINATION OF PAYMENT TO PROVIDERS; QUALITY MANAGEMENT PAYMENTS

"SEC. 1842. (a) The Administration shall periodically determine (subject to subsection (b)) the amount which should be paid under this title to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Administration believes appropriate (but not less often than monthly) and prior to audit of settlement by the General Accounting Office, from the National Health Car Trust Fund, the amounts due determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider under this title for the period with respect to which the amounts are being paid or any prior period.

"(b) (1) (A) There is established within each geographic area (as established under section 1511 of the Public Health Service Act) an area health care services board (hereinafter in this section referred to as the 'area board'), which shall consist of fifteen members, not otherwise in the employ of the United States, appointed by the Administration on recommendation of the elected legislative bodies of such counties or independent cities as exist within such area, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

"(B) The members of the area board shall include five persons who are representatives of providers of health services, and of ten persons who are representatives of consumers of such services, and of twenty persons who are representatives of consumers of such services. Each member shall hold office for a term of five years, except that (i) any member appointed to fill a vacancy occurring during the term for which his or her predecessor was appointed shall be appointed for the remainder of that term, and (ii) the terms of the members first taking office shall expire, as designated by the Administration at the time of the appointment, three at the end of the first year, three at the end of the second year, three at the end of the third year, three at the end of the fourth year, three at the end of the fifth year. Members of the area board who are representatives of providers of health care shall be persons who are outstanding in fields related to medical, hospital, or other health activities within such area, or who are representatives of organizations or associations of professional health personnel within such area; members who are representatives of consumers of such care shall be persons, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the furnishing of such services, and who, in aggregate, otherwise accurately reflect a socioeconomic cross section of such area.

"(C) Section 14(a)(2) of the Federal Advisory Committee Act shall not apply with respect to the area boards.

"(D) Each area board is authorized to appoint such professional or technical committees, from its own members or from other persons or both, as may be useful in carrying out its functions. Each area board, its members, and its committees shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Administration for carrying out their respective functions. Each area board shall meet as frequently as the Administration deems necessary, but not less often than four times each year. Upon request by seven or more members it shall be the duty of the chairperson previously chosen by an area board to call a meeting of the area board.

"(E) Members of each area board and members of technical or professional committees, while serving on business of the area board (inclusive of traveltime), shall receive compensation at rates fixed by the Administration, but not in excess of the daily rate in effect for GS-15 of the General Schedule; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"(2) The Administration after consultation with the area boards shall develop and make available to providers of services one or more methods of obtaining payment on a prospective basis for services furnished under this title. Such providers will have the option of electing to utilize any one of such prospective payment methods. Once a provider elects a particular prospective payment method, it may not alter its election without the prior approval of the Administration in consultation with the area board for the area in which the provider provides services under this title. Where the Administration finds that the number of providers electing a prospective payment method promulgated in accordance with this paragraph is not sufficient to provide an adequate basis for either operation or evaluation of that method, or that the method does not achieve improved results, then the Administration shall withdraw that method and allow electing providers to select another method within forty-five days of notice of such withdrawal.

"(3) In addition to the method or methods for establishing prospective rates or amounts made available to providers in a State or area (as established under section 1511 of the Public Health Services Act) another method for establishing prospective rates or amounts where the Administration finds that the State or area plan for prospective payment, as developed by either the State or the area board, is consistent with the policies expressed in this subsection.

"(4) Prior to the initial publication of any prospective payment method under paragraph (2), or the approval of any alternate prospective payment method under paragraph (3), the Administration shall give sixty days notice thereof to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

"(5) Prospective payment methods authorized under this subsection shall include in their design provisions (A) for financial incentives for efficiency and effectiveness of provider operations equal to the potential difference between the prospective rate or amount and the actual rate or amount, (B) which provide assurances to providers of services that their total income from all patient care will be equal to their financial requirements (subject to section 1122), (C) to assure the substantial participation by providers in such prospective payment methods, (D) to assure the availability of institutional services of high quality to beneficiaries and recipients under this title, and (E) for maintaining independent management discretion and responsibility in such providers.

"(6) Any payment method which the Administration establishes or approves under paragraphs (2) and (3) must recognize in the establishment of the prospective rate or amount the providers' total cost of operation of facilities and services which have been approved under section 1122, including (A) the unrecovered costs due to credit losses and patient's inability to pay; (B) the costs associated with agreed upon working capital needs; and (C) the cost of financing approved capital facility or services projects.

"(7) (A) Any payment method which the Administration establishes or approves under paragraph (2) or (3) shall not be modified once established with respect to an accounting period except under the circumstances described in subparagraph (B).

"(B) The Administration by regulation shall provide for adjustment to the agreed upon prospective rate amount for (i) unforeseeable events such as natural catastrophes and (ii) significant and unexpected change in demand for services or for unexpected or significant changes in patient mix not under control of the provider.

"(C) A provider shall have the right to appeal a decision under subparagraph (B) to the Provider Reimbursement Review Board as authorized under section 1860.

"(8) Any payment method which the Administration establishes or approves under paragraph (2) or (3) must include provision for a return on the equity invested in the provision of services, with the Administration determining annually a reasonable rate, after consideration of rates of return on investment of comparable risk and with such rate being included as a factor in the determination of the prospective rate or amount in the case of for-profit providers. Amounts shall also be included in determining the prospective rate or amount for not-for-profit providers in order to give appropriate recognition to the risk assumed under a prospective payment method.

"(9) Any prospective payment method established under subsection shall exclude from reimbursement under this title in any calendar year the amount of any expenses of the provider which are paid by a State or local government in such year (or, if higher, an amount of the expenses of such provider which were paid by a State or local government in the calendar year 1974).

"(10) Following publication of final regulations governing the method or methods of determining prospective rates or amounts under this subsection each provider shall have a period of sixty days within which to select one of the prospective payment methods for the first fiscal year beginning more than ninety days after the end of such sixty-day period.

"(11) The Administration shall submit to the Congress annually a full report on the impact of prospective payment methods on the efficiency and effectiveness of provider operations. It shall include in its report an evaluation of the effects on the utilization and quality of the services of providers.

"(c) (1) The Administration, in consultation with the area boards, shall promulgate a system of incentive payments as appropriate in accordance with the provisions of this subsection.

"(2) The Administration shall award on an annual basis quality management payments to any provider of services under this title whenever the percentage amount or the dollar amount of increase in such provider's prospective rate (as defined by the Administration) for a fiscal year is less than the average annual increase in such rate for the three previous fiscal years for all providers in the same class as defined in accordance with paragraph (4).

"(3) The quality management payment to any provider under this subsection shall be equal to 50 per centum of the difference between such provider's total costs to the program and what its costs to the program would have been had they increased at the class average rate as computed for the purpose of paragraph (2).

"(4) For purposes of preparing similar classes of providers under paragraph (2), the Administration shall develop and utilize a comparison methodology for grouping and comparing similar providers of services. Prior to the implementation of this paragraph the Administration shall consult with the area boards.

"(5) Where a provider's increase, as computed under paragraph (2), exceeds the class average (as computed under paragraph (2)) with respect to a fiscal year, one-half of the difference between such provider's increase and the class average shall be added to such provider's increase in the subsequent fiscal year for purposes of computing any future entitlement to any quality management payment under this subsection.

"(6) (A) In recognition of the significant contribution to improved management practices by staff personnel and members of the medical staff, each provider which receives a quality management payment under this subsection shall distribute at least two-thirds of the amount of such payment to the employees and members of the medical staff under a plan approved by the governing board of such provider and made known to such employees and such members of the medical staff.

"(B) Any amounts paid to employees under the provisions of subparagraph (A) shall not be considered costs for the purposes of the computation required under paragraph (2), and the Administration shall promulgate annually the names (and other identifying information) of all providers which receive quality management payments under this subsection.

"(7) Quality management payments under this subsection shall be made from the National Health Care Trust Fund. The Administration shall submit to the Congress annually a full report on the quality management payments made under this subsection. The Administration shall include in its report an evaluation of the impact of such payments on the efficiency and effectiveness of these payments on the utilization and quality of hospital services.

"AGREEMENTS WITH PROVIDERS OF SERVICES

"SEC. 1843. (a) (1) Any provider of services shall be qualified to participate under this title and shall be eligible for payments under this title if it files with an Administration an agreement—

"(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he or she would be entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1841 (d)),

"(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of section 1811 (a) (2) (A) or (G), but only if (i) such individual was without fault in incurring such expenses and (ii) the Administration's determination that such payments may not be made for such items and services was made after the second year following the year in which notice of such payment was sent to such individual; except that the Administration may reduce such two-year period to not less than one year if it finds such reduction is consistent with the objectives of this title, and

"(C) to make adequate provision for return (or other disposition), in accordance with regulations of any moneys incorrectly collected from such individuals or other person. An agreement under this paragraph with an extended care facility shall be for a term of not exceeding twelve months, except that the Administration may extend such term for a period of not exceeding two months, where the health and safety of patients will not be jeopardized thereby, if it finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if it finds it impracticable within such twelve-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.

"(2) A provider of services may charge such individual or other person to the extent that the amount customarily charged by it for items or services specifically requested by such individual or other person exceeds the amount customarily charged by it for the items and services with respect to which payment may be made under this title where the provider of services has furnished, at such request, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title.

"(b) An agreement with the Administration under this section may be terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a) (1))—

"(1) by the provider of services at such time and upon such notice to the Administration and the public as may be provided in regulations, except that notice of more than four months shall not be required, or

"(2) by the Administration at such time and upon such reasonable to the provider of services and the public as may be specified in regulations, but only after the Administration, with the concurrence of the local area board (established under section 1842(b) (1)), has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1851, or (C) that such provider of services has failed to provide such information as the Administration finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examinations of its fiscal and other records by or on behalf of the Administration as may be necessary to verify such information, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Administration to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

Any termination shall be applicable—

"(3) in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

"(4) (A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

"(5) with respect to any other items and services furnished on or after the effective date of such termination.

"(c) Where an agreement filed under this title by a provider of services has been terminated by the Administration, such provider may not file another agreement under this title unless the Administration, with the concurrence of the local area board (established under section 1842 (b) (1)) finds that the reason for the termination has been removed and that there is reasonable reassurance that it will not recur.

"(d) If the Administration, with the concurrence of the local area board (established under section 1842 (b) (1)), finds that there is a substantial failure to make timely review in accordance with section 1851 (k) of long-stay cases in a hospital or skilled nursing facility, it may, in lieu of terminating its agreement with such hospital or facility, after a subsequent date specified by it, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the twentieth day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the administration, with the concurrence of the local area board, finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur.

"(c) For purposes of this section, the term 'provider of services' shall include a clinic, rehabilitation agency, or public health agency if, in the case of a rehabilitation agency or clinic, such agency or clinic meets the requirements of section 1851 (o) (4) (A), or if, in the case of a public health agency, such agency meets the requirements of section 1851 (o) (4) (B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined).

"USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

"Sec. 1844. (a) If any group or association of providers of services wishes to have payments under this title to such providers made through a National, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Administration is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1860 and to such review by the Administration as may be provided for by the agreement) of the amount of the payments required pursuant to this title to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Administration, and serve as a channel of communication from providers to the Administration; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this title; and (C) to perform such other functions as are necessary to carry out this subsection.

"(b) The Administration shall not enter into an agreement with any agency or organization under this section unless (1) it finds (A) that to do so is consistent with the effective and efficient administration of this title, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this title in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to benefits under this title, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Administration such of the information acquired by it in carrying out its agreement under this section as the Administration may find necessary in performing its functions under this title.

"(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Administration finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Administration to be necessary and proper for carrying out the functions covered by the agreement.

"(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Administration of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Administration under this section if the Administration and such agency or organization agree to it.

"(e) An agreement with the Administration under this section may be terminated—

"(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Administration, to the public, and to providers as may be provided in regulations, or

"(2) by the Administration at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if it finds, after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this title.

"(f) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Administration may deem appropriate.

"(g) (1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him or her under this section.

"(2) No disbursing officer shall, in the absences of gross negligence or intent to defraud the United States, be liable with respect to any payment by him or her under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

"USE OF CARRIERS FOR ADMINISTRATION OF NONINSTITUTIONAL BENEFITS

"SEC. 1845. (a) (1) In order to provide for the administration of the benefits furnished under this title by persons other than providers of services with maximum efficiency and convenience for individuals entitled to benefits under this title and for providers of services and other persons furnishing services to such individuals during the initial period of effectiveness of this title, the Administration is authorized, in the manner provided in subsection (c), to enter into contracts with carriers (as defined in section 1851 (x)), including carriers with which agreements under section 1844 are in effect, which qualify under subsection (b) and will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performances thereof by other organizations); and, with respect to any of the following functions, the Administration shall, to the extent consistent with the efficient administration of this title, enter into such contracts:

"(A) receive, disburse, and account for funds in making payments for services furnished under this title by persons other than providers of services;

"(B) serve as a channel of communication of information relating to the administration of this title; and

"(C) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this title.

"(b) A carrier is qualified for purposes of subsection (a) only if—

"(1) during the calendar year 1974 at least 1 percent of the total dollar value of health insurance outstanding in the United States was written or underwritten by such carrier,

"(2) such carrier demonstrates to the satisfaction of the Administration, in such manner and form as the Administration may require, that it is capable of efficient and effective claims operations, and agrees to utilize standard claims processing forms and procedures established by the Administration under subsection (c) (4), and

"(3) such carrier demonstrates to the satisfaction of the Administration, in such manner and form as the Administration may require, that it has not discriminated against any person on account of race, creed, color, or sex in employment, writing or underwriting health insurance, in claims operations in the two years prior to the effective date of any contract under subsection (a).

"(c) (1) The Administration shall establish, keep current, and make public a complete list of all qualified carriers in the United States.

"(2) The Administration shall divide the United States into geographic regions for purposes of this section, taking into account the outstanding contracts entered into by employers under paragraph (3), the locations of the various qualified carriers and their principal offices, and the probable demand or need for health care and services under this title in each such region. Any qualified carrier on the list established under paragraph (1) which maintains one or more offices in any region may submit to the Administration an offer to enter into a contract under subsection (a) for the administration of the noninstitutional benefits under this title within that region; and the carrier with which the Administration, with the concurrence of each area board (as established under section 1842 (b) (1)) within that region, enters into such a contract with respect to that region shall (subject to paragraph (3)) have full responsibility for the administration of such benefits in that region in accordance with this section.

"(3) Notwithstanding any other provision of this section, any corporation, firm, or other person which employed an average of one thousand or more individuals in the conduct of its trade or business during the preceding calendar year may select any carrier on the list established under paragraph (1) (or, alternately, may elect to deal directly with the Administration) for the administration of benefits under this title with respect to its employees.

"(4) The Administration shall establish standard claims, forms and processing procedures designed to minimize administrative burdens on physicians and others who furnish services covered under this title.

"(d) (1) Contracts with carriers under subsection (a) shall be subject to section 3709 of the Revised Statutes and to any other provision of law requiring competitive bidding.

"(2) No such contract shall be entered into with any carrier unless the Administration finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as it finds pertinent.

"(3) Each such contract shall provide that the carrier—

"(A) will make all payments authorized by this title for noninstitutional services, as provided in this section;

"(B) will take such action as may be necessary to assure that payment under this title for noninstitutional services will be in accordance with subsection (b);

"(C) will furnish to the Administration such timely information and reports as it may find necessary in performing its functions under this title; and

"(D) will maintain such records and afford such access thereto as the Administration finds necessary to assure the correctness and verification of the information and reports under subparagraph (C) and otherwise to carry out the purposes of this title;

and shall contain such other terms and conditions not inconsistent with this section as the Administration may find necessary or appropriate.

"(4) Each contract under this section shall be for a term of at least two years, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that (A) the Administration may terminate any such contract at any time (after such reasonable notice and opportunity to the carrier involved and the public as it may provide in regulations) if it finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the health care program established by this title, and (B) the Administration shall terminate all such contracts no later than ten years from the effective date of this title.

"(e) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this title and, in the case of a carrier selected by an employer under subsection (c) (3), shall provide for payment of the cost of administration of the carrier, as determined by the Administration to be necessary and proper for carrying out the functions covered by the contract.

"(f) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Administration may deem appropriate.

"(g) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him or her under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him or her under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

"PAYMENT TO PHYSICIANS AND OTHER HEALTH PROFESSIONALS

"SEC. 1846. (a) Payment under this title for services rendered by a physician within any area established under section 1511 of the Public Health Services Act shall be made in accordance with a single fee schedule applicable throughout the area, as described in subsection (b).

"(b) The fee schedule described in subsection (a) which is applicable with respect to services rendered in any area shall be determined as follows:

"(1) The schedule to be in effect in such for the twelve month period beginning on the effective date of this title shall be proposed by the area board established under section 1842(b)(1) in such area; and the schedule so proposed shall be approved by the Administration if it finds (utilizing professional actuarial expertise) that the total costs of the services involved in such area, adjusted to the extent that the Administration finds (on the basis of appropriate economic index data) to be justified by economic changes, would have been no higher for the calendar year 1973 than they were in fact had such schedule been in effect throughout that year.

"(2) Except as provided in paragraphs (3) and (4), the schedule to be in effect in such area for any twelve-month period beginning on October 1 after the period specified in paragraph (1) shall be the schedule which was in effect in such area for the period specified in paragraph (1), adjusted to the extent that the administration finds (on the basis of appropriate economic index data) to be justified by economic changes.

"(3) A new or modified schedule to be in effect in such area for any twelve-month period may be proposed at any time by the area board in such area; and any schedule so proposed shall be approved by the Administration (in lieu of a schedule under paragraph (2)) if it finds (utilizing professional actuarial expertise) that the total costs of the services involved under the new or proposed schedule will be no higher for such twelve-month period than they would have been had the schedule been determined under paragraph (2) for such period.

"(4) In any case where no schedule is proposed to be in effect in such area for any period as provided in the preceding paragraphs of this subsection, or where the Administration is unable to approve the schedule so proposed, the Administration shall establish and place in effect in such area for that period a fee schedule, which shall be equivalent to the fee schedule theretofore proposed and approved under such paragraphs for another area which is determined by the Administration to be similar to such area.

"(c) All physicians may elect, in such manner and form as the Administration shall by regulations prescribe, whether to participate or not to participate, in the manner provided in subsection (d) (1), in the program under this title. Any such physician desiring to participate may do so upon giving thirty days' written notice to the Administration that he or she will accept payment of the fee schedule amount as payment in full for the services he or she provides to all individuals eligible for benefits under this title. Any participating physician desiring to rescind his or her participation may do so upon giving ninety days' written notice to the Administration and to all of his or her current patients, but may again participate in such programs only upon the expiration of twelve months after his or her most recent participation ceased (and upon giving thirty days' written notice after such twelve-month period to the Administration).

"(d) (1) Any physician electing to participate in the program under this title as provided in subsection (c) shall receive payment for any services furnished by him or her in the State, under this title, on the basis of regular billings (which shall be submitted on the same type of claims form) in accordance with the fee schedule which is effective in the area for the period involved, and shall receive pursuant to section 1832 such payments in the full amounts specified in such schedule. At the option of the physician, such billings and the payments made pursuant thereto may be made on a consolidated basis under which the physician uses a single form to list all of the services involved under both programs over such period (not less than a week) as shall be specified by the Administration, and receives a single check including payment for all of the services so listed.

"(2) Payments under this title to physicians who have not elected to participate in such programs as provided in subsection (c), and to patients of such physicians, for services specified in the fee schedule which is effective in the area for the period involved, shall be made in the amounts specified in such schedule.

"(e) Each fee schedule in effect under the preceding provisions of this subsection, and the names and addresses of all participating physicians within the meaning of subsection (c) shall be made available to the public throughout the State involved, in such manner and at such times as the Administration may consider appropriate, by the Administration or by the appropriate State agency with the approval of the Administration.

"(f) The amount payable under this title in the case of other medical services, supplies, and equipment (including equipment servicing) which, in the judgment of the Administration, do not generally vary significantly in quality from one supplier to another, may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in the area involved except to the extent and under the circumstances specified by the Administration.

"SPECIAL PROVISIONS RELATING TO OUTPATIENT DRUGS AND BIOLOGICALS

"National Health Care Formulary Committee

"SEC. 1847. (a) (1) (A) There is hereby established, within the Social Security Administration, a National Health Care Formulary Committee (hereinafter referred to as the 'Committee'), which shall consist of the Commissioner of Food and Drugs and of three individuals (not otherwise in the employ of the Federal Government) who do not have a direct or indirect financial interest in the compensation of the Formulary established and who are of recognized professional standing and distinction in the fields of medicine, pharmacology, and pharmacy, and one individual who does not have a direct or indirect financial or professional interest in the provision of health care services or items, to be appointed by the Administration without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Chairperson of the Committee shall be elected annually from the appointed members thereof, by majority vote of the members of the Committee.

"(B) Each appointed member of the Committee shall hold office for a term of five years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Administration at the time of appointment, one at the end of each of the first five years. A member shall not be eligible to serve continuously for more than two terms.

"(2) Appointed members of the Committee, while attending meetings or conferences thereof or otherwise serving on business of the Committee, shall be entitled to receive compensation at rates fixed by the Administration (but not in excess of the daily rate paid under GS–18 of the General Schedule under section 5332 of title 5, United States Code), including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, as authorized by section 5703 of title 5, United States Code, for persons in the Government service.

"(3) (A) The Committee is authorized, with the approval of the Administration, to engage or contract for such technical assistance as may be required to carry out its functions, and the Administration shall, in addition, make available to the Committee such secretarial, clerical, and other assistance as the Formulary Committee may require to carry out its functions.

"(B) The Administration shall furnish to the Committee such office space, materials, and equipment as may be necessary for the Formulary Committee to carry out its functions.

"Formulary

"(b) (1) (A) The Committee shall compile, publish, and make available a National Health Care Formulary (hereinafter in this section referred to as the 'Formulary').

"(B) The Committee shall periodically revise the Formulary and the listing of drugs so as to maintain currency in the contents thereof.

"(2) (A) The Formulary shall contain an alphabetically arranged listing, by established name, of those drug entities within the following therapeutic categories:

"Adrenocorticoids;

"Anti-anginals;

"Anti-arrhythmics;

"Anti-coagulants;

"Anti-convulsants (excluding phenobarbital);

"Anti-hypertensives;

"Anti-neoplastics;

"Anti-Parkinsonism agents;

"Anti-rheumatics;

"Bronchodilators;

"Cardiotonics;

"Cholinesterase inhibitors;

"Diuretics;

"Gout suppressants;

"Hypoglycemics;

"Miotics;

"Oral contraceptives;

"Thyroid hormones;

"Tuberculostatics;

which the Committee decides are necessary for individuals using such drugs. The Committee shall exclude from the Formulary any drug entities (or dosage forms and strengths thereof) which the Committee decides are not necessary for proper patient care, taking into account other drug entities (or dosage forms and strengths thereof) which are included in the Formulary.

"(B) Such listing shall include the specific dosage forms and strengths of each drug entity (included in the Formulary in accordance with subparagraph (A)) which the Committee decides are necessary for individuals using such drugs.

"(C) Such listing shall include the prices at which the products (in the same dosage form and strength) of such drug entities are generally sold by the suppliers thereof and the limit applicable under subsection (d) for purposes of determining the reasonable allowance.

"(D) The Committee may also include in the Formulary, either as a separate part (or parts) thereof or as a supplement (or supplements) thereto, any or all of the following information:

"(i) A supplemental list or lists, arranged by diagnostic, prophylactic, therapeutic, or other classifications, of the drug entities (and dosage forms and strengths thereof) included in the listing referred to in subparagraph (A).

"(ii) The proprietary names under which products of a drug entity listed in the Formulary by established name (and dosage form and strength) are sold and the names of each supplier thereof.

"(iii) Any other information with respect to eligible drug entities which in the judgment of the Committee would be useful in carrying out the purposes of this part.

"(3) In considering whether a particular drug entity (or strength or dosage form thereof) shall be included in or excluded from the Formulary, the Committee is authorized to obtain (upon request therefor) any record pertaining to the characteristics of such drug entity which is available to any other department, agency, or instrumentality of the Federal Government, and to request suppliers or manufacturers of drugs and other knowledgeable persons or organizations to make available to the Committee information relating to such drug. If any such record or information (or any information contained in such record) is of a confidential nature, the Committee shall respect the confidentiality of such record or information and shall limit its usage thereof to the proper exercise of its authority.

"(4) (A) the Committee shall establish such procedures as it determines to be necessary in its evaluation of the appropriateness of the inclusion in or exclusion from the Formulary of any drug entity (or dosage form or strength thereof). For purposes of inclusion in or exclusion from the Formulary, the principal factors in the determination of the Committee shall be:

"(i) the factor of clinical equivalence in the case of the same dosage forms in the same strengths of the same drug entity, and

"(ii) the factor of relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category.

"(B) The Committee, prior to making a final decision to remove from listing in the Formulary any drug entity (or dosage forms or strengths thereof) which is included therein, shall afford a reasonable opportunity for a formal or informal hearing on the matter to any person engaged in manufacturing, preparing, compounding, or processing such drug entity who shows reasonable ground for such a hearing.

"(C) Any person engaged in the manufacture, preparation, compounding, or processing of any drug entity (or dosage forms or strengths thereof) not included in the Formulary which such person believes to possess the requisite qualities to entitle such drug to be included in the Formulary pursuant to subsection (a), may petition for inclusion of such drug entity and, if such petition is denied by the Formulary Committee, shall, upon request therefor, showing reasonable grounds for a hearing, be afforded a formal or informal hearing on the matter in accordance with rules and procedures established by such Committee.

"Limitations on Payment for Charges of Providers of Services

"(c) (1) Any provider whose services are otherwise reimbursable, under this title or any other program under this Act in which there is Federal financial participation on the basis of 'reasonable cost', shall not be entitled to a professional fee or dispensing charge or reasonable allowance as determined to this section.

"(2) A fee, charge, or billing allowance shall not be payable under this section with respect to any drug entity that (as determined in accordance with regulations) is furnished as an incident to a physician's professional service, and is of a kind commonly furnished in physicians' offices and commonly either rendered without charge or included in the physician's bills.

"Reasonable Allowance for Outpatient Drugs and Biologicals

"(d) (1) For purposes of this section, the term 'reasonable allowance' when used with respect to outpatient drugs and biologicals means—

"(A) when used with respect to a reimbursable drug other than insulin the amount determined under paragraph (2) of this section, and

"(B) when used with respect to an insulin product, an amount determined by the Administration, including a reasonable billing allowance.

"(2) The amount applicable under paragraph (1) (A) shall be the sum of—

"(A) an amount equal to the price of such reimbursable drug as ascertained under paragraph (3), and

"(B) the pharmaceutical service charge as determined under paragraph (4).

"(3) (A) From time to time (but not less often than annually), the Administration shall, subject to subparagraph (B), ascertain the prices of a drug, however named, at which the ultimate dispensers thereof acquire such drug. Any drug, however named, the price of which exceeds 125 per centum of the average price of such drug shall not be a reimbursable drug for purposes of this part.

"(B) Whenever the price at which a drug is generally available for sale to the ultimate dispensers thereof varies significantly among the various regions of the United States, or among classes of ultimate dispensers, the Administration may determine an average price with respect to such drug for various regions or for various classes of its ultimate dispensers.

"(4) (A) Each participating licensed pharmacy shall file annually, in such form as may be prescribed by the Administration, a statement of its pharmaceutical service charge with the Administration.

"(B) The pharmaceutical service charge for purposes of paragraph (2) (B) with respect to any participating licensed pharmacy shall be the pharmaceutical service charge filed under subparagraph (A), except that any such charge which exceeds 90 per centum of the average such charge for licensed participating pharmacies in the same area (as established under section 1152) shall be reduced to the 90 per centum level.

"(C) With respect to years after the first year for which a pharmaceutical service charge is filed, the 90 per centum amount under subparagraph (B) shall be adjusted by the Administration to the extent necessary on the basis of appropriate economic index data.

"Special Provisions for Physicians Dispensing Outpatient Drugs and Biologicals

"(e) (1) This subsection shall apply, notwithstanding any other provisions in this title, where the Administration determines that no participating licensed pharmacies exist in a community.

"(2) Any physician practicing in a community with respect to which the Administration has made a determination is deemed to be a licensed participating pharmacy for purposes of this title if such physician files the required agreement and statement with the Administration.

"(3) In cases where a licensed participating pharmacy exists in a community only because of paragraph (2), the reasonable allowance for an outpatient drug or biological under this section shall be no larger than the amount specified in subsection (d) (2) (A).

"NATIONAL HEALTH CARE TRUST FUND

"SEC. 1848. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'National Health Care Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be deposited in, or appropriated to, such fund as provided in this title (and in section 102(e) of the Comprehensive National Health Care Act of 1975). There are hereby appropriated to the Trust Fund for each fiscal year, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his or her delegate pursuant to subtitle F of such Code (including unearned income treated as wages pursuant to section 3126(c) of such Code), as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Board of the Social Security Administration in accordance with such reports; and

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his or her delegate on tax returns under subtitle F of such Code (including unearned income treated as wages pursuant to section 3126(c) of such Code), as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, the Chairperson of the Board of the Social Security Administration, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Executive Director of the Social Security Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

"(1) hold the Trust Fund;

"(2) report to the Congress not later than the first day of March of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years;

"(3) report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small or unduly large; and

"(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursement to be made from, the Trust Fund during the current fiscal year and each of the next two fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his or her judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of two years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he or she determines that the purchase of such other obligations is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

"(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the other Trust Funds established by this Act amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments pursuant to section 1856 of this Act.

"(g) There shall be transferred periodically (but not less often than once each fiscal year) from the Trust Fund to the Secretary of Health, Education, and Welfare for purposes of title XVI of the Public Health Service Act the following amounts:

"(1) For the fiscal year ending September 30, 1978, an amount equivalent to 2 per centum of the total of all amounts deposited in the Trust Fund in the fiscal year ending September 30, 1977.

"(2) For the fiscal year ending September 30, 1979, an amount equivalent to 1½ per centum of the total of all amounts deposited in the Trust Fund in the fiscal year ending September 30, 1978.

"(3) For the fiscal year ending September 30, 1980, an amount equivalent to 1¼ per centum of the total of all amounts deposited in the Trust Fund in the fiscal year ending September 30, 1979.

"(4) For the fiscal year ending September 30, 1981, and each succeeding fiscal year, an amount equal to 1 per centum of the total of all amounts deposited in the Trust Fund in the preceding fiscal year.

"(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Administration certifies are necessary to make (1) the payments provided for by this title, and (2) the payments with respect to administrative expenses provided by section 201 (g) (1).

"PART E—MISCELLANEOUS PROVISIONS

"DEFINITIONS

"SEC. 1851. For purposes of this title—

"Inpatient Hospital Services

"(a) The term 'inpatient hospital services' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board;

"(2) such nursing services and other related services, such as use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

"(4) medical or surgical services provided by a physician who is not an employee of the hospital; and

"(5) the services of a private-duty nurse or other private-duty attendant.

"Hospital

"(b) The term 'hospital' means, except with respect to emergency services provided outside the United States, an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) maintains clinical records on all patients;

"(3) has bylaws in effect with respect to its staff or physicians;

"(4) has a requirement that every patient must be under the care of a physician;

"(5) provides twenty four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

"(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

"(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

"(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

Notwithstanding the preceding provisions of this subsection, such term shall not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a psychiatric hospital (as defined in subsection (c)) or unless it is a tuberculosis hospital (as defined in subsection (d)). The term 'hospital' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

"Psychiatric Hospital

"(c) The term 'psychiatric hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfied paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'psychiatric hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Tuberculosis Hospital

"(d) The term 'tuberculosis hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'tuberculosis hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct parts meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Physicians' Services

"(e) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls.

"Physician

"(f) The term 'physician', when used in connection with the performance of any function or action, means, except with respect to emergency services provided outside the United States, (1) a doctor of medicine or osteopathy, other than an intern, resident, or fellow, legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101 (a) (7)), (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he or she performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw, or (B) the reduction of any fracture of the jaw or any facial bone, (3) a doctor of optometry who is legally authorized to practice optometry by the State in which he or she performs such function, but only with respect to establishing the necessity for prosthetic lenses, or (4) except for the purposes of subsections (j), (k), (m), and (n), a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him or her) only with respect to functions which he or she is legally authorized to perform in the State in which he or she performs them.

"Medical and Other Health Services

"(g) The term 'medical and other health services' means any of the following items or services—

"(1) physicians' services;

"(2) (A) services, other than physician extender services, and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

"(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) other than physician extender services, incident to physician's services rendered to outpatients;

"(C) diagnostic services which are—

"(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and "(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

"(D) outpatient physical therapy services; and

"(E) physician extender services;

"(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Administration may find necessary), diagnostic laboratory tests, and other diagnostic tests;

"(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

"(5) surgical dressings, and splints, casts, and other devices used for a reduction of fractures and dislocations;

"(6) durable medical equipment, including dialysis equipment and supplies, iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his or her home other than an institution that meets the requirements of subsection (b) (1) or (j) (1) of this section), whether furnished on a rental basis or purchased;

"(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

"(8) prosthetic devices which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; and

"(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (3) unless such laboratory—

"(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

"(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2) (C) any item or service (except services referred to in paragraph (1)) which—

"(12) would not be included under subsection (a) if it were furnished to an inpatient or a hospital; or

"(13) is furnished under arrangements referred to in such paragraph (2) (C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

"Extended Care Services

"(h) The term 'extended care services' means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6) of such skilled nursing facility—

"(1) nursing care provided by or under the supervision of a registered professional nurse;

"(2) bed and board in connection with the furnishing of such nursing care;

"(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

"(4) medical social services;

"(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility as are ordinarily furnished by such facility for the care and treatment of inpatients;

"(6) medical services provided by an intern, resident-in-training, or fellow of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

"(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities; excluding, however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

POST-HOSPITAL EXTENDED CARE SERVICES

"(i) The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital in which he or she was an inpatient for not less than three consecutive days before his or her discharge from the hospital in connection with such transfer, and for so long as he or she remains in the skilled nursing facility providing the services and is not discharged from it. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he or she shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he or she is admitted to the skilled nursing facility—

"(1) within fourteen days after discharge from such hospital, or

"(2) within twenty-eight days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such fourteen days because of a shortage of appropriate bed space in the geographic area (as established under section 1511 of the Public Health Service Act) in which he or she resides, or

"(3) Within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within fourteen days after discharge from a hospital. An individual shall be deemed not to have been discharged from a skilled nursing facility if, within fourteen days after discharge therefrom, he or she is admitted to such facility or any other skilled nursing facility.

"Skilled Nursing Facility

"(j) The term 'skilled nursing facility' means an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more certified hospitals, which is under the direction of an administrator licensed under the laws of the State in which it is located, and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

"(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

"(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

"(5) maintains clinical records on all patients;

"(6) provides twenty-four hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

"(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"(8) has in effect a utilization review plan which meets the requirements of subsection (k);

"(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institution of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

"(10) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

"(11) meets such provisions of the Life Safety Code of the National Fire Protection (twenty-first edition, 1967) as are applicable to nursing homes; except that the provisions of such Code shall not apply in any State if the Administration finds that in each State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities; and

"(12) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Administration may find necessary.

The term 'skilled nursing facility' also includes a Christian Science Sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such an institution to inpatients.

"Utilization Review

"(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to health care benefits under this title and if it provides—

"(1) for the review of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by a group outside the institution which is composed of two or more physicians with the participation of other professional personnel and (A) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality or (B) if (and for as long as) there has not been established such a group which serves such institution, which is established by the local area board;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day: and

"(4) for prompt notification to the institution, the individual, and his or her attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such group that any further stay in the institution is not medically necessary.

"Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

"(1) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which has attempted in good faith to enter into such agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as to do so is determined by the local area board to be in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

"Home Health Services

"(m) The term 'home health services' means the following items and services furnished to an individual, confined to his or her home (except when receiving items and services referred to in clause (7)) and in need of skilled nursing care on an intermittent basis, or physical or speech therapy, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan for furnishing such items and services to such individual established and periodically reviewed by a physican, which items and services are, except as provided in paragraph (7), provided on a visting basis in the place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital; and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

"(B) which are furnished at such facility while he or she is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

"Home health agency

"(n) The term 'home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which—

"(1) is primarily engaging in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

"(5) meets such other conditions, standards, and requirements as the Administration may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization.

"Outpatient Physical Therapy Services

"(o) The term 'outpatient physical therapy services' means physical therapy services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

"(1) who is under the care of a physician, and

"(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician;

excluding, however—

"(3) any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital; and

"(4) any such service—

"(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or rehabilitation agency, unless such clinic or agency—

"(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such program, in accordance with such requirements as the Administration may specify,

"(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with a clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

"(iii) maintains clinical records on all patients,

"(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing, and

"(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency as the Administration may find necessary, or

"(B) if furnished by a public health agency, unless such agency meets such other conditions relating to the health and safety of individuals who are furnished services by such agency, as the Administration may find necessary.

In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or skilled nursing facility. The term 'outpatient physical therapy services' also includes speech pathology services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

"Drugs and Biologicals

"(p) The term 'drugs' and the term 'biologicals', except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are required by section 503(b) of the Federal Food, Drug, and Cosmetic Act to be dispensed only upon prescription, and such other drugs and biologicals as the Administration may by regulation provide.

"Outpatient Drugs and Biologicals

"(q) The term 'outpatient drugs and biologicals' means any drug or biological which (1) can be self-administered, (2) requires a physician's prescription (except for insulin), (3) is prescribed when the individual requiring such drug is not an inpatient in a hospital or extended care facility, during a period of covered care, (4) is included by strength and dosage forms among the drugs and biologicals approved by the Formulary Committee, (5) is dispensed (except as provided by section 1841 (g)), by a pharmacist from a participating pharmacy, and (6) is dispensed in quantities consistent with proper medical practice and reasonable professional discretion.

"Routine Dental Services

"(r) The term 'routine dental services' means services in connection with the examination, care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth provided by a dentist or an assistant to a dentist working under his or her supervision, except that it does not include orthodontic services.

"Dentist

"(s) The term 'dentist', when used in connection with the performance of any function, means a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he or she performs such function.

"Eyeglasses

"(t) The term 'eyeglasses' means lenses for the correction of a vision defect provided on the basis of an eye examination.

"Eye and Vision Examination

"(u) The term 'eye and vision examination' means an examination for the purpose of determining the need for eyeglasses or vision care, or prescribing, fitting, or changing eyeglasses, performed by an individual who may legally perform such examination in the State in which it is performed.

"Hearing Aids and Examinations

"(v) The term 'hearing aids and examinations' means devices for the correction of hearing defects and examinations for the purpose of determining the need for such a device, subject to such limitations and restrictions as the Administration may by regulation provide.

"Physician Extender Services

"(w) The term 'physician extender services' means services performed under the supervision and control of a physician by a physician's assistant, nurse practitioner, or other individual, whether or not performed in the office of such physician or at a place at which he or she is present, if—

"(1) the services are related to the practice by the supervising physician of general medicine, family medicine, internal medicine, geriatrics, or such other medical specialties as the Administration may by regulation prescribe,

"(2) the individual has—

"(A) successfully completed an appropriate training program approved by the Administration or by an accrediting organization approved by the Administration, or

"(B) passed a physician extender certification examination conducted by a certifying organization approved by the Administration which does not have as a prerequisite graduation from an accredited training program, or

"(C) met such other proficiency requirements as the Administration may by regulation prescribe,

"(3) the individual may legally perform the services in the State in which the services are performed,

"(4) under the law of the State in which the services are performed, the individual acts, in performing the services, as the agent or otherwise on behalf of the supervising physician or organization which employs the individual, and

"(5) the charges for such services are included in the bills of the supervising physician or the employing organization.

"Arrangements for Certain Services

"(y) The term 'arrangements' is limited to arrangements under which receipt of payment by a hospital, skilled nursing facility, or home health agency (whether in its own right or as agency), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"State and United States

"(z) The terms 'State' and 'United States' have the meaning given to them by subsections (h) and (i), respectively, of section 210.

"Provider of services

"(aa) The term 'provider of services' means a hospital, skilled nursing facility, or home health agency, and includes a neighborhood health center (as defined in regulations), a community mental health center (as defined in the Community Mental Health Centers Act), or a health maintenance organization meeting the requirements of section 1301 of the Public Health Service Act.

"Participating Pharmacy

"(bb) The term 'participating pharmacy' means a pharmacy, or other establishment (including the outpatient department of a hospital) providing pharmaceutical services (1) which is licensed as such under the laws of the State (where such State requires such licensure) or which is otherwise lawfully providing pharmaceutical services in which outpatient drugs and biologicals are provided or otherwise dispensed in accordance with this title, (2) which has agreed with the Administration to act as a provider of services in accordance with the requirements of this section, and which complies with such other requirements as may be established by the Administration in regulations to assure the proper, economical, and efficient administration of this title, (3) which has agreed to submit, at such frequency and in such form as may be prescribed in regulations, bills for amounts payable under this title for such drugs and biologicals furnished under this title, and (4) which has agreed not to charge beneficiaries under this title any amounts in excess of those allowable under this title with respect to outpatient drugs and biologicals.

"CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

"SEC. 1852. In carrying out its functions relating to determination of conditions of participation by providers of services, the Administration shall consult with appropriate State agencies, recognized national listing or accrediting bodies, and area health care services boards. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements in institutions as a condition to the purchase of services (or of certain specified services), the Administration shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such State or subdivision.

"USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

"Sec. 1853. (a) The Administration shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or area board) will be utilized by the Administration for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1851(g), or whether a clinic, rehabilitation agency, or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1851 (o) (4). To the extent that the Administration finds it appropriate, an institution or agency which such a State agency (or area health care services board) certifies is a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1851) may be treated as such by the Administration. Any State agency which has such an agreement may (subject to approval of the Administration) furnish to an extended care facility, after proper request by such facility, such specialized consultive services (which such agency is able and willing to furnish in a manner satisfactory to the Administration) as such facility may need to meet one or more of the conditions specified in section 1851 (j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within sixty days following the completion of each survey of any health care facility, laboratory, clinic, agency, or organization by the appropriate State agency or area board described in the first sentence of this subsection, the Administration shall make public in readily available form and place the findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title, and (2) the additional conditions which the Administration finds necessary in the interest of the health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

"(b) The Administration shall pay any such State or area health care services board in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the National Health Care Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under this title, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"(c) The Administration is authorized to enter into an agreement with any State under which the appropriate State agency or area board which performs the certification function described in subsection (a) will survey, on a selective random sample basis (or where the Administration finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect the health and safety of patients), hospitals which have an agreement with the Administration under section 1843 and which are accredited by the Joint Commission on the Accreditation of Hospitals. The Administration shall pay for such services in the manner prescribed in subsection (b).

"EFFECT OF ACCREDITATION

"SEC. 1854. (a) Except as provided in subsection (b) and the second sentence of section 1843, if—

"(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

"(2) such institution (if it is included within a survey described in section 1853 (c)) authorizes the Commission to release to the Administration (on a confidential basis) upon its request (or such State agency as the Administrator may designate) a copy of the most current accreditation survey of such institution made by such Commission,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1851 (b); except—

"(3) paragraph (6) thereof, and

"(4) any standard, promulgated by the Administration pursuant to paragraph (8) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Administration determines is at least equivalent to the standard promulgated by the Administration as described in paragraph (4) of this subsection, the Administration is authorized to find that all institutions so accredited by such Commission comply also with section 1851 (b) (6) or the standard described in such paragraph (4), as the case may be. In addition, if the Administration finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1851 (b), (j), or (n), as the case may be, are met, it may, to the extent it deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which it made such finding.

"(b) Notwithstanding any other provision of this title, if the Administration finds following a survey made pursuant to section 1853 (c) that an institution has significant deficiencies (as defined in regulations pertaining to health and safety), such institution shall, after the date of notice of such finding to the institution and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1851 (b).

"DETERMINATIONS; APPEALS

"SEC. 1855. (a) The determination of whether an individual is entitled to benefits under this title, and the determination of the amount of such benefits, shall be made by the Administration in accordance with regulations prescribed by it.

"(b) (1) Any individual dissatisfied with any determination under subsection (a) as to—

"(A) whether he or she meets the conditions of eligibility for benefits under this title, or

"(B) the amount of benefits under this title (including a determination where such amount is determined to be zero),

shall be entitled to a hearing thereon by the Administration to the same extent as is provided in section 205 (b) and to judicial review of the Administration's final decision after such hearing as is provided in section 205 (g).

"(2) Notwithstanding the provisions of subparagraph (B) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (B) if the amount in controversy is less than $50; nor shall a judicial review be available to an individual by reason of such subparagraph (B) if the amount in controversy is less than $500.

"(c) Any institution or agency dissatisfied with any determination by the Administration that it is not a provider of services, or with any determination described in section 1843 (b) (2), shall be entitled to a hearing thereon by the Administration to the same extent as is provided in section 205 (b), and to judicial review of the Administration's final decision after such hearing as is provided in section 205 (g).

"OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

"SEC. 1856. (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

"(b) Where—

"(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Administration determines (A) that, within such period as it may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

"(2) any payment has been made under section 1841 (d) to a provider of services or other person for items or services furnished an individual,

proper adjustment shall be made, under regulations prescribed by the Administration, by decreasing subsequent payments—

"(3) to which such individual is entitled under title II of this Act, or

"(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of this Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Administration, for the purposes of this section, shall certify the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Administration's determination that more than such correct amount was paid was made subsequent to the first year following the year in which notice was sent to such individual that such amount had been paid; except that the Administration may reduce such one-year period to not less than four months if it finds such reduction is consistent with the objectives of this title.

"(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1841 (d)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b) (4), if such adjustment (or recovery) would defeat the purposes of title II or this title or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Administration determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items and services for which payment may not be made under this title by reasons of the provisions of section 1811 (a) (2) (A) or (E), and (B) the Administration's determination that such payment was incorrect was made subsequent to the first year following the year in which notice of such payment was sent to such individual; except that the Administration may reduce such one-year period to not less than four months if it finds such reduction is consistent with the objectives of this title.

"(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him or her to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

"(e) If an individual, who received services for which payment may be made to such individual under this title, dies, and payment for such services was made (other than under this title), and the individual died before any payments due him or her under this title with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

"(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Administration under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his or her death, to the legal representative of the estate of such deceased individual, if any;

"(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Administration to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his or her death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

"(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him or her under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

"(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him or her under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one parent, in equal parts to each such parent);

"(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him or her under this title is completed, to the person, if any, determined by the Administration to be the surviving spouse of the deceased individual;

"(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him or her under this title is completed, to the person or persons, if any, determined by the Administration to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child); or

"(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him or her under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent).

"(f) If an individual who received medical and other health services for which payment may be made under this title dies, and—

"(1) no assignment of the right to payments was made by such individual before his or her death, and

"(2) payment for such services has not been made, payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1857. The provisions of sections 206 and 216 (j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"SEC. 1858. Designation in this title, by name, or any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Administration finds serves the purpose for which such designation is made.

"PENALTIES

"SEC. 1859. (a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefits or payment,

"(3) having knowledge of the concurrence of any event affecting (A) his or her initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

"(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

"(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of any false statements or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1851), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"PROVIDER REIMBURSEMENT REVIEW BOARD

"SEC. 1860. (a) ESTABLISHMENT.—Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter in this section referred to as the 'Board') which shall be established by the Administration in accordance with subsection (g) of this section, if—

"(1) such provider—

"(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1844 or 1845 of this title as to the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report,

"(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Administration relating to such report, or

"(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply;

"(2) the amount in controversy is $5,000 or more, and

"(3) such provider files a request for a hearing within ninety days after notice of the intermediary's final determination under paragraph (1) (A) or with respect to appeals pursuant to paragraph (1) (B) or (C), within one hundred and twenty days after such cost report was filed.

"(b) APPEALS BY GROUPS.—The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $5,000 limitation), be entitled to such a hearing, but only if the matters of controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $30,000 or more.

"(c) RIGHT TO COUNSEL; RULES OF EVIDENCE.—At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

"(d) DECISIONS OF THE BOARD.—A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

"(e) RULES AND REGULATIONS.—The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Administration, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations.

"(f) REVIEW OF BOARD'S DECISION.—A decision of the Board shall be final unless the Administration, within thirty days after the provider of services is notified of the Board's decision, reverses or modifies (adversely to such provider) the Board's decision. In any case where such reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within thirty days of the date he or she is notified of the Administration's reversal or modification. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code.

"(g) COMPOSITION AND COMPENSATION.—The Board shall be composed of nine members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. At least three of such members shall be representatives of providers of services. At least five of such members shall have no direct or indirect financial interest in providing health care services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Administration, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS–18 in section 5332 of title 5, United

States Code. The term of office shall be three years, except that the Administration shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

"(h) TECHNICAL AND CLERICAL ASSISTANCE.—The Board is authorized to engage such technical and clerical assistance as may be required to carry out its functions, and the Administration shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

"NATIONAL HEALTH CARE BENEFITS ADVISORY COUNCIL

"SEC. 1861. (a) There is hereby created a National Health Care Benefits Advisory Council which shall consist of nineteen persons, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Administration shall, from time to time, appoint one of the members to serve as Chairperson. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, and persons who are representative of organizations and associations of professional personnel in the field of health. At least nine persons who are representative of the general public and have no direct or indirect financial interest in providing health care services shall be on the Council. Each member shall hold office for a term of five years, except that any member appointed to fill a vacancy occuring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Administration, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Administration deems necessary, but not less than annually.

"(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Administration on matters of general policy with respect to this title.

"(c) Section 14(a)(2) of the Federal Advisory Committee Act shall not apply with respect to the Advisory Council.

"REGULATIONS

"SEC. 1862. The Administration shall prescribe such regulations as may be necessary to carry out the administration of the health care program under this title. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Administration with the concurrence of the Advisory Council.".

TAXES AND COVERAGE FOR HEALTH CARE PURPOSES

SEC. 102. (a) (1) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income) is amended by deleting subsection (b) (relating to hospital insurance) and adding at the end thereof the following new subsection:

"(b) NATIONAL HEALTH CARE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual (including unearned income of such individual to the extent provided in section 3126(c) (1)), a tax for purposes of the national health care program under title XVIII of the Social Security Act in an amount equal to 5 percent of the amount of the self-employment income (and unearned income) for such taxable year.".

(2) Section 3101 of such Code (relating to rate of tax on employees) is amended by deleting subsection (b) (relating to hospital insurance) and adding at the end thereof the following new subsection:

"(b) NATIONAL HEALTH CARE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual (including unearned income of such individual to the extent provided in section 3126(c)(1)) a tax for purposes of the national health care program under title XVIII of the Social Security Act in an amount equal to 2 percent of the wages (as defined in section 3121(a) and modified by section 3126 (a)) received by him or her with respect to employment as defined in section 3126(b) (including any such unearned income).".

(3) Section 3111 of such Code (relating to tax on employers) is amended by deleting subsection (b) (relating to hospital insurance) and adding at the end thereof the following new subsection:

"(b) NATIONAL HEALTH CARE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax with respect to having individuals in his or her employ, for purposes of the national health care program under title XVIII of the Social Security Act, equal to 6 percent of the wages (as defined in section

3121 (a) and modified by section 3126 (a)) paid by him or her with respect to employment as defined in section 3126 (b) (including unearned income of such individuals to the extent provided in section 3126 (c) (1)) .".

(b) (1) Subchapter C of chapter 21 of such Code (general provisions under Federal Insurance Contributions Act) is amended by redesignating section 3126 as section 3127, and by inserting immediately after section the following new section:

"SEC. 3126. SPECIAL COVERAGE PROVISIONS FOR PURPOSES OF NATIONAL HEALTH CARE TAXES.

"(a) CONTRIBUTION AND BENEFIT BASE.—The contribution and benefit base for purposes of the taxes imposed by sections 3101 (b) and 3111 (b) (as a limitation or maximum under sections 3121 (a) (1), 3122, 3125, 6413, and 6654) shall, subject to section 230 of the Social Security Act, be unlimited. Such sections 3121 (a) (1), 3122, 3125, 6413, and 6654 shall be applied with respect to the contribution and benefit base for purposes of these taxes separately from the corresponding contribution and benefit base for purposes of the other taxes imposed by sections 3101 and 3111. The contribution and benefit base specified in the first sentence of this subsection shall (under regulations prescribed by the Secretary) apply with respect to the combined wages and the self-employment income (and unearned income) of any husband and wife who are eligible to file a joint return (for the taxable year involved) under section 6013 as well as with respect to the wages and self-employment income (and unearned income) of an individual (other than such husband or wife).

"(b) COVERED EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), the term 'employment' has the meaning given it by section 3121(b) except that—

"(1) paragraph (5) of such section (exclusion for certain federally related service), paragraph (7) of such section (exclusion for State or local employment), paragraph (8)(B) of such section (exclusion for employment by certain nonprofit organizations), and paragraph (9) of such section (exclusion for service covered by Railroad Retirement Act) shall not apply; and

"(2) paragraph (6) of such section (exclusion for Federal employment) shall apply only with respect to service performed by an individual as a member of a uniformed service on active duty outside the United States.

"(c) INCLUSION OF UNEARNED INCOME WITHIN CONTRIBUTION AND BENEFIT BASE IN CERTAIN CASES.—

"(1) IN GENERAL.—In any case where the total of an individual's wages and net earnings from self-employment income for a taxable year (determined without regard to this subsection) is less than the applicable contribution and benefit base as determined under subsection (a), and such individual has any unearned income (as defined in paragraph (2)) for such year, so much of such unearned income as does not exceed the difference between such total and such contribution and benefit base—

"(A) shall be included in such base as 'wages' and treated as subject to the taxes imposed by sections 3101(b) and 3111(b), to the extent that it consists of payments of aid to families with dependent children under a State plan approved under section 402 of the Social Security Act or supplemental security income benefits under title XVI of such Act, and

"(B) shall, to the extent that it consists of unearned income in any other form (and that any part of such difference remains after the application of subparagraph (A)), be included in such base as 'self-employed income' and treated as subject to the tax imposed by section 1401(c).

"(2) DEFINITION OF UNEARNED INCOME.—As used in paragraph (1), the term 'unearned income' with respect to any individual means—

"(A) the amount of such individual's adjusted gross income for the taxable year, including payments of aid to families with dependent children under a State plan approved under section 402 of the Social Security Act, supplemental security income benefits under title XVI of such Act, and any amounts referred to in subparagraphs (B) and (F) of section 1612 (a) (2) of such Act to the extent not otherwise includible in such income, reduced by

"(B) any part of such income (whether from wages or any other source) in excess of the amount of the contribution and benefit base for purposes of the taxes under sections 3101 (b) and 3111 (b) for such year (as determined under subsection (a)), and further reduced by

"(C) any part of the remaining adjusted gross income which consists of—

"(i) wages taxable under section 3101 (b), or

"(ii) self-employment income taxable under section 1401 (b), or

"(iii) remuneration for services performed as a member of a uniformed service on active duty outside the United States, or "(iv) remuneration (not taxable under section 3101(b)) for services performed by an alien in the employ of a foreign government, or an instrumentality of a foreign government, or an international organization.

"(3) EXCLUSION FOR THE AGED AND DISABLED.— This subsection shall not apply with respect to any individual who, at any time during the taxable year, satisfies paragraph (1) or (2) of section 226(b) or is under the age of 18.".

(2) The table of sections for such subchapter C is amended by striking out the last item and inserting in lieu thereof the following:

"Sec. 3126. Special coverage provisions for purposes of national health care taxes.
"Sec. 3127. Short title.".

(c) (1) Section 1402(b) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by adding at the end thereof the following new sentence: "The contribution and benefit base for purposes of the tax imposed by section 1401(b) (as a limitation or maximus under this subsection) shall, subject to section 230 of the Social Security Act, be unlimited.".

(2) (A) Section 3121(b) of such Code (relating to definition of employment) is amended by striking out "such term shall not include" in the matter preceding paragraph

(1) and inserting in lieu thereof "such term (subject to section 3126 (b)) shall not include".

(B) Section 3121 (m) of such Code (relating to service in the uniformed services) is amended by inserting after "chapter" in the matter preceding paragraph (1) the following: "subject to section 3126 (b))".

(3) Section 230 (c) of the Social Security Act is amended by striking out "shall be $13,200" and inserting in lieu thereof "shall be unlimited in a case to which section 3126 (a) of the Internal Revenue Code of 1954 applies and $13,200 in any other case,".

(d) (1) Section 3102 of the Internal Revenue Code of 1954 (relating to deduction of tax from wages) is amended by adding at the end thereof the following new subsection:

"(d) HEALTH CARE TAX ON CERTAIN UNEARNED INCOME TREATED AS WAGES.—The tax imposed by section 3101 (b) with respect to payments of aid to families with dependent children or supplemental security income benefits (and treated as a tax on wages under section 3126 (c) (1) (A)) shall be collected by the State agency making such payments or the Federal agency paying such benefits by deducting and withholding the amount of the tax from such payments or benefits as and when paid; and thereafter for all of the purposes of this title and title XVIII of the Social Security Act (1) such agency and the recipient of any such payment or benefit shall be considered to have been employer and employee, respectively, and (2) such payment or benefit shall be treated as constituting remuneration paid by such agency to the recipient for employment. Any amount deducted and withheld from a payment or benefit under the preceding sentence shall be separately shown and clearly identified as the tax imposed by section 3101(b) for purposes of the national health care program.".

(2) Section 1403 of such Code (miscellaneous provisions) is amended by redesignating subsection (b) as subsection (c), and by inserting after subsection (a) the following new subsection:

"(b) ARRANGEMENTS FOR DEDUCTION AND WITHHOLDING OF TAX ON CERTAIN UNEARNED INCOME TREATED AS SELF-EMPLOYMENT INCOME.—The Secretary, in connection with the Board of the Social Security Administration, is authorized to enter into appropriate arrangements with public and private agencies and organizations making payments to individuals which (under subsections (c) (1) (B) and (c) (2) (A) of section 3126) constitute unearned income of such individuals subject to the tax imposed by section 1401 (b), for the collection of such tax by such agencies and organizations on behalf of such individuals by deduction and withholding from such payments.".

TAX REFUNDS FOR CERTAIN SERVICE PERSONNEL AND OTHERS

SEC. 103. (a) (1) (A) Section 6413 of the Internal Revenue Code of 1954 (special rules applicable to certain employment taxes) is amended by redesignating subsection (d) as subsection (e), and by inserting after subsection (c) the following new subsection:

"(d) SPECIAL REFUNDS OF HEALTH INSURANCE TAX UPON APPLICATION BY SERVICE PERSONNEL PERFORMING OTHER EMPLOYMENT.—

"(1) IN GENERAL.—If an individual performing service as a member of a uniformed service on active duty outside the United States (excluded from health care coverage under section 3126 (b) (3)) also performs service which constitutes employment for purposes of the tax imposed by section 3101 (b), such individual shall upon application be entitled (subject to the provisions of section 31 (b)) to a credit or refund of any amount of tax, with respect to the wages paid for such employment, imposed by such section 3101 (b) and deducted from the individual's wages (whether or not paid to the Secretary).

"(2) NOTIFICATION TO SECRETARY OF HEALTH, EDUCATION, AND WELFARE.—The Secretary shall promptly notify the Secretary of Health, Education, and

Welfare of such special refund allowed under this subsection.".

(B) Section 6413 (c) of such Code (relating to special refunds) is amended—

(i) by inserting "Based on Multiple Employment" after "Refunds" in the heading; and

(ii) by inserting after "during such year" where it appears in clauses (G) and (H) of paragraph (1) the following: "(after the application of subsection (d) in any case to which it applies)".

(2) Section 31 (b) of such Code (relating to credit for special refunds of social security tax) is amended—

(A) by inserting "or 6413 (d)" after "section 6413 (c)" in paragraph (1); and

(B) by inserting after "to which paragraph (1) applies" in paragraph (2) the following: "and which represents a special refund allowable under section 6413 (c)".

(b) Chapter A of the Internal Revenue Code of 1954 is amended by inserting after section 42 the following new section:

"SEC. 43. CREDITS FOR PAYMENTS OF NATIONAL HEALTH CARE TAXES.

"(a) GENERAL RULE.—There shall be allowed, as a credit against the tax imposed by this chapter, an amount equal to one-half the amount paid within a taxable year by the taxpayer for taxes imposed—

"(1) by section 1401(b) (relating to national health care);

"(2) by section 3101(b) (relating to national health care); and

"(3) by section 3111(b) (relating to national health care).

"(b) LIMITATIONS.—

"(1) The credit allowed by paragraphs (1) and (2) of subsection (a) shall be limited to $250 ($500 in the case of a joint return under section 6013); and

"(2) The amount allowed by subsection (a)(3) shall be limited to the amount equal to the product of $750 times the number of individuals for which the tax imposed by section 3111(b) was paid within the taxable year."

(c) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1975.

PROFESSIONAL STANDARDS REVIEW

SEC. 104. Section 1155 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(h) Beginning no later than two years after the effective date of title XVIII, each Professional Standards Review Organization shall perform the same functions with respect to the review of professional activities involving items and services for which payment may be made under title XVIII, in the area which it serves, as such organization performs (in such area) with respect to professional activities involving items and services for which payment may be made under other provisions of this Act.".

TITLE II—INDEPENDENT SOCIAL SECURITY ADMINISTRATION

DECLARATION OF PURPOSE

SEC. 301. (a) The purpose of this title is to strengthen the fiscal and administrative structure of the contributory social security programs. These programs constitute a retirement and group-insurance plan that provides nearly all American workers and their families with protection designed to partly make up for the loss of earned income during retirement, during periods of extended and total disability before retirement age, or because of death, and provide protection against the costs of medical care. In conjunction with the program of supplemental security income to the needy, designed to fill the gaps in insurance protection, these contributory social insurance programs form a universal structure of economic security. It is essential that we take every practical step to insure the long-range fiscal integrity of these programs, and to provide for nonpolitical, objective, and skilled program administration.

(b) In creating the contributory social security and health care program, the Congress has undertaken a fiscal obligation which differs in essential respects from its obligations under programs financed in other ways. The distinctive nature of this obligation results from (1) the contributory character of the programs which gives to nearly every American a personal financial stake in future benefit rights, (2) the concomitant obligation of Government to assure beyond peradventure that these rights earned by compulsory contributions and based on past earnings will, in fact, be honored when they fall due whether in the near or the distant future, (3) the dependence of the programs, if this assurance is to be fully credible, on adequate long-term sources of income dedicated exclusively to these programs, (4) the need that changes in these systems which may be required to meet changing economic and social conditions be developed on a long-range basis and in the context of their interrelated benefit and financial structures. In order to assure more completely the full recognition of the fiscal obligations inherent in these programs, this title separates the transactions of the self-financed social insurance programs from the transactions of the general budget.

(c) The magnitude of these social insurance programs and of the supplemental security income program—in terms of the number of people affected by them, the volume of income and expenditures, the number of persons engaged in their operation, the nationwide network of local offices, and the complexity of these huge operations—demands the utmost in skillful, nonpolitical administration. To help assure such administration and continuously high levels of service to the beneficiaries of and contributors to the programs, this title constitutes the Social Security Administration as an independent agency in the executive branch, responsible directly to the President. The independence accorded by this change will also serve to emphasize to the public that the Government's role in the insurance program is essentially that of trustee and manager for those who have worked in covered employment and contributed to the support of the programs, a role which is markedly different and carries different obligations from the Government's role in programs financed in other ways.

SOCIAL SECURITY ADMINISTRATION

Sec. 202. (a) Title VII of the Social Security Act is amended by inserting immediately before section 702 the following new section:

"SOCIAL SECURITY ADMINISTRATION

"Sec. 701. (a) (1) There is hereby established, as an independent agency of the executive branch of the Government, a Social Security Administration (hereinafter in this section referred to as the 'Administration'). The Administration shall be headed by a Board which shall consist of three members who shall be appointed by the President, by and with the advice and consent of the Senate. The President shall, from time to time, designate one of the members as chairperson of the Board.

"(2) No individual shall, during the time that he or she holds the office as a member of the Board, engage in any business, vocation, or employment, other than the discharge of his or her duties and the exercise of his or her authority as a member of the Board.

"(3) Not more than two of the members of the Board shall be members of the same political party.

"(4) Each member of the Board shall hold office for a term of five years, except that (A) a member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed, shall be appointed for the remainder of such term, and (B) the terms of office of the members first taking office after the date of enactment of the Act to establish the Social Security Administration as an independent agency shall expire, as designated by the President at the time of appointment, one at the end of two years, one at the end of four years, and one at the end of five years, after the date of enactment of such Act.

"(5) Actions taken, and decisions made by, members of the Board shall be by majority vote; and any action so taken, or decision so made, shall be the action or decision of the Administration.

"(b) (1) It shall be the duty of the Administration to administer the programs established by titles II, XVI, and XVIII of this Act, and to discharge the duties and responsibilities imposed on the Secretary of Health, Education, and Welfare in connection with the administration of the program established by title IV of the Federal Coal Mine Health and Safety Act of 1969.

"(2) The Administration shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning the programs referred to in paragraph (1), and to other programs having similar objectives.

"(3) The Administration shall prepare and submit to the Congress an annual report on its activities, which report shall include the recommendations of the Administration made pursuant to paragraph (2).

"(c) (1) There shall be in the Administration an Executive Director, who shall be appointed by and serve at the pleasure of the Administration, and who shall perform such functions concerning the programs administered by the Administration as the Administration may prescribe.

"(2) There shall be in the Administration a General Counsel, who shall be appointed by and serve at the pleasure of the Administration, and who shall be the principal legal counsel in the Administration. The Administration may obtain the services of experts and consultants in accordance with the provisions of section 3109 of title 5, United States Code.".

(b) Section 702 of such Act is amended by inserting immediately before the period at the end thereof the following: "; except that nothing in this section shall be construed to require the Secretary to make studies of or recommendations with respect to programs administered by the Social Security Administration".

(c) Section 706 of such Act is amended—

(1) by striking out "Secretary" wherever it appears and inserting in lieu thereof "Social Security Administration",

(2) by striking out "Department of Health, Education, and Welfare" in subsection (c) (1) and inserting in lieu thereof "Social Security Administration", and

(3) by striking out "the public assistance programs under this Act" in subsection (a) and inserting in lieu

thereof "the program established by title XVI of this Act".

(d) Section 201 (c) of such Act is amended—

(1) by inserting "the Chairperson of the Board of the Social Security Administration," immediately after "Secretary of Labor," in the first sentence, and

(2) by striking out "Commissioner of Social Security" in the third sentence and inserting in lieu thereof "Executive Director of the Social Security Administration".

(e) The last sentence of section 205 (g) of such Act is amended by striking out "in the person occupying the office of Secretary or any vacancy in such office" and inserting in lieu thereof "in the membership of the Board of the Social Security Administration or any vacancy in the membership of such Board".

(f) Title II (except the first sentence of section 201 (c) and the last sentence of section 205 (g)), part B of title XI and title XVI (as enacted by section 301 of the Social Security Amendments of 1972) of the Social Security Act are each amended—

(1) by striking out "Secretary of Health, Education, and Welfare" wherever it appears and inserting in lieu thereof "Social Security Administration",

(2) by striking out "Department of Health, Education, and Welfare" wherever it appears and inserting in lieu thereof "Social Security Administration",

(3) by striking out "Department" wherever it appears (but only if it is not immediately succeeded by the words "of Health, Education, and Welfare", and only if it is used in reference to the Department of Health, Education, and Welfare) and inserting in lieu thereof "Social Security Administration", and

(4) by striking out each of the following words wherever it appears (but, in the case of any such word, only if it refers to the Secretary of Health, Education, and Welfare) : "Secretary", "Secretary's", "his", "him", and "he", and by inserting in lieu thereof (in the case of the word "Secretary") "Social Security Administration", (in the case of the word "Secretary's") "Social Security Administration's", (in the case of the word "his") "the Social Security Administration's", (in the case of the word "him") "the Social Security Administration", and (in the case of the word "he") "the Social Security Administration".

(g) Section 1101 (a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(9) The term 'Administration', except when the context otherwise requires, means the Social Security Administration established by section 701.".

(h) This title and the amendment made by this title shall take effect January 1, 1976.

TRANSITIONAL PROVISIONS

SEC. 203. (a) (1) Except as provided in paragraph (2), the term "Secretary of Health, Education, and Welfare" and the term "Secretary", when used to refer to the Secretary of Health, Education, and Welfare, shall be deemed to refer to the Social Security Administration when (and to the extent that) such term is employed in any provision of law which imposes any duty or responsibility on, confers any authority on, or imposes any limitation on the exercise of authority by, the Secretary of Health, Education, and Welfare with respect to the administration of the programs established by (a) title II, XVI (as enacted by section 301 of the Social Security Amendments of 1972), or XVIII of the Social Security Act, or (B) part IV of the Federal Coal Mine Health and Safety Act of 1969.

(2) The provisions of paragraph (1) shall not apply to any provision of law which is contained in (A) title II, XVI (as enacted by section 301 of the Social Security Amendments of 1972), or XVIII of the Social Security Act, (B) title IV of the Federal Coal Mine Health and

Safety Act, or (C) section 1122 of the Social Security Act, or part B of title XI of such Act.

(b) (1) There are transferred to the Social Security Administration (as established by section 701 of the Social Security Act under the amendment made by section 202 (a) of this Act) all functions carried out by the Secretary of Health, Education, and Welfare with respect to the administration of programs and activities the administration of which is vested in such Administration by reason of this Act and the amendments made thereby.

(2) There are transferred to the Social Security Administration (as established by section 701 of the Social Security Act under the amendment made by section 202 (a) of this Act) all personnel, assets, liabilities, contracts, property, and records which the Director of the Office of Management and Budget determines to be employed, held, or used by the Secretary of Health, Education, and Welfare primarily in connection with the functions, activities, and programs which, by reason of this Act and the amendments made thereby, are vested in or become the responsibility of such Administration.

(3) The position of Commissioner of Social Security is abolished.

(c) (1) All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges—

(A) which have been issued, made, promulgated, granted, or allowed to become effective, in the exercise of Health, Education, and Welfare (or his or her delegate), and (ii) which relates to functions which, by means of this Act and the amendments made thereby, are vested in the Social Security Administration (as established by section 701 of the Social Security Act under the amendment made by subsection 202(a) of this Act), and

(B) which are in effect at the time this title takes effect,

shall (to the extent that they relate to functions described in subparagraph (A) (ii)) continue in effect according to their terms until modified, terminated, suspended, set aside, or repealed by the Social Security Administration (as so established).

(2) The provisions of this title (including the amendments made thereby) shall not affect any proceeding pending at the time this title takes effect before the Secretary of Health, Education, and Welfare with respect to functions vested (by reason of this title and amendments made thereby) in the Social Security Administration (as established by section 701 of the Social Security Act under the amendment made by section 202(a) of this Act), except that such proceedings, to the extent that they relate to such

functions, shall continue before the Social Security Administration (as so established). Orders shall be issued under any such proceeding, appeals taken therefrom, and payments shall be made pursuant to such orders, in like manner as if this title had not been enacted, and orders issued in any such proceeding shall continue in effect until modified, terminated, superseded, or repealed by the Social Security Administration (as so established), by a court of competent jurisdiction, or by operation of law.

(3) Except as provided in this paragraph—

(1) the provisions of this title shall not effect suits commenced prior to the date this title takes effect; and

(2) in all such suits proceedings shall be had, appeals taken, and judgments rendered, in the same manner and effect as if this title had not been enacted.

No cause of action, and no suit, action, or other proceeding commenced by or against any officer in his or her official capacity as an officer of the Department of Health, Education, and Welfare, shall abate by reason of the enactment of this title. Causes of actions, suits, or other proceedings may be asserted by or against the United States and the Social Security Administration (as established by section 701 of the Social Security Act under the amendment made by section 202(a) of this Act), or such official of such Administration as may be appropriate, and, in any litigation pending when this section takes effect, the court may at any time, on its own motion or that of a party, enter an order which will give effect to the provisions of this subsection (including, where appropriate, an order for substitution of parties).

(4) This title shall not have the effect of releasing or extinguishing any criminal prosecution, penalty, forfeiture, or liability incurred as a result of any function which (by reason of this title) is vested in the Social Security Administration.

(5) Orders and actions of the Social Security Administration in the exercise of functions vested in such Administration under this title (and the amendments made thereby) shall be subject to judicial review to the same extent and in the same manner as if such orders and actions had been taken by the Secretary of Health, Education, and Welfare in the exercise of such functions immediately preceding the effective date of this title. Any statutory requirements relating to notice, hearings, action upon the record, or administrative review that apply to any function so vested in the Social Security Administration shall continue to apply to the exercise of such function by such Administration.

(6) In the exercise of the functions vested in it under this title (and the amendments made thereby), the Social Security Administration shall have the same authority as

that vested in the Secretary of Health, Education, and Welfare with respect to the exercise of such functions immediately preceding the vesting of same in such Administration, and actions of such Administration shall have the same force and effect as when exercised by such Secretary.

MISCELLANEOUS AND CONFORMING AMENDMENTS

SEC. 204. Title IV of the Federal Coal Mine Health and Safety Act of 1969 is amended—

(a) in section 402 (c), by striking out "where used in part B means the Secretary of Health, Education, and Welfare, and", and

(b) in all provisions thereof (other than section 402 (c) and section 427)—

(1) by striking out "Secretary of Health, Education, and Welfare" wherever it appears and inserting in lieu thereof "Social Security Administration", and

(2) by striking out each of the following words wherever it appears (but, in the case of any such word, only if such word refers to the Secretary of Health, Education, and Welfare): "Secretary", "Secretary's", "his", "him", and "he", and by inserting in lieu thereof (in the case of the word "Secretary") "Social Security Administration", (in the case of the word "Secretary's") "Social Security

Administration's", (in the case of the word "his") "the Social Security Administration's", (in the case of the word "him") "the Social Security Administration". and (in the case of the word "he") "the Social Security Administration".

Sec. 205. (a) Section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), is amended—

(1) by striking out "The Budget" in the second sentence of subsection (a) and inserting in lieu thereof "Except as provided in subsection (d), the Budget"; and

(2) by adding at the end thereof the following new subsection:

"(d) The Budget shall set forth the items referred to in paragraphs (4), (5), (6), (7), (8), (9), and (12) of subsection (a) which are attributable to receipts of expenditures from the general fund of the Treasury (commonly referred to as the 'administrative budget'), and shall set forth separately such items which are attributabe to receipts of and expenditures from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Trust Fund, and the National Health Care Trust Fund.".

(b) The amendments made by subsection (a) shall apply with respect to the budget for the fiscal year ending September 30, 1977, and for each fiscal year thereafter.

SEC. 206. (a) Section 5313 of title 5, United States Code (relating to level II of the Executive Schedule), is amended by adding at the end thereof the following new paragraph:

"(22) Chairperson of the Board of the Social Security Administration.".

(b) Section 5314 of such title (relating to level III of the Executive Schedule) is amended by adding at the end thereof the following new paragraphs:

"(60) Member of the Board of the Social Security Administration.

"(61) Executive Director, Social Security Administration.".

(c) Section 5315 of such title (relating to level IV of the Executive Schedule) is amended by striking out—

"(97) Commissioner of Social Security, Department of Health, Education, and Welfare.",

and by inserting in lieu thereof—

"(97) General Counsel, Social Security Administration.".

EFFECTIVE DATE

SEC. 207. (a) This title, and the amendments made by this title, shall take effect on the first day of the first calendar year which begins not less than ninety days after the date of enactment of this title.

(b) Notwithstanding the provisions of subsection (a), the members of the Board of the Social Security Administration may be appointed prior to the effective date of this title, but after the date of enactment of this title; and the Executive Director and the General Counsel of such Administration may be appointed by such Administration at any time after all members of the Board of such Administration have been appointed. The officers referred to in the preceding sentence shall be compensated from the date they first take office, at the rates provided for in the amendments to title 5, United States Code, made by section 206 of this Act. Such compensation and related expenses of such officers shall be paid from funds available for the functions vested in the Social Security Administration by this title and the amendments made thereby.

TITLE III—MISCELLANEOUS PROVISIONS

EXISTING EMPLOYER-EMPLOYEE HEALTH BENEFIT PLANS UNAFFECTED

SEC. 301. (a) No provision of this Act and no amendment made by this Act, shall effect or alter any contractual or other nonstatutory obligation of an employer to pay for or provide health services to his or her present and former employees and their dependents, and to their survivors, or to any of such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the costs of such services.

(b) Any contractual or other nonstatutory obligation of the employer to pay all or part of the cost of the health services referred to in subsection (a) shall continue in respect of the payment of taxes imposed on his or her employees by section 3101 (b) of the Internal Revenue Code of 1954, but the sum of the per capita monthly amount involved in the payment of such taxes by the employer on behalf of his or her employees and the per capita amount of the liability for taxes imposed on an employer by section 3111 (b) of the Internal Revenue Code of 1954, shall not exceed the per capita monthly amount of the cost to the employer of providing or paying for health services (either through insurance premiums or into a fund) equivalent to those provided under the amendment made by section 101 of this Act on behalf of persons referred to in subsection (a) for the month prior to the effective date of the taxes imposed by section 102 (a) of this Act.

(c) At least for the duration of any contractual or other nonstatutory obligation of an employer referred to in subsection (a) the employer shall arrange to pay to the persons referred to in subsection (a) the amounts of money by which the per capita monthly costs to the employer of providing or paying for health services referred to in subsection (a) in the month immediately preceding the effective date of the taxes imposed by section 102 (a) of this Act exceed the sum of the per capita monthly costs to the employer of the provisions of section 102 (a) (3) of this Act, the employer's liability referred to in subsection (b), and any other employer contributions for health insurance premiums of health benefits or services provided by the employer after the effective date of section 101 of this Act. By mutual agreement between the employer and his or her employees or their representatives, an employer may provide other benefits of an equivalent monetary value in lieu of such payments.

PLANNING BY HEALTH CARE PROVIDERS AND CONDITIONS FOR PAYMENT

SEC. 302. Section 1122 of the Social Security Act is amended to read as follows:

"PLANNING BY HEALTH CARE PROVIDERS AND CONDITIONS FOR PAYMENT

"SEC. 1122. (a) It is the purpose of this section to assure that Federal funds appropriated or made available under titles V and XVIII are used to finance providers' health care services that conform to State and areawide plans for health facilities and services, and to encourage thereby the better utilization of existing resources and the development of additional resources in ways that assure economy of operation while improving the accessibility and quality of health services to all beneficiaries of the programs under such titles.

"(b) The Board through its intermediaries shall allow in prospective budgets of providers of health care services only those types and amounts of services and facilities which the planning agencies designated in section 314(a) of the Public Health Service Act (and, where they exist, the agencies designated in section 314(b) of such Act) have approved in writing, except where the Board finds—

"(1) that the planning agency involved has held the provider's proposal without action for more than sixty days,

"(2) the planning agency has not afforded the provider a reasonable opportunity for a fair hearing, or

"(3) the action taken by the planning agency is determined by the Board to be arbitrary and capricious.

"(c) No capital expenditure (as defined in subsection (f)) may be made by any provider of services, and no lease or comparable arrangement shall be entered into under subsection (d) by such provider, without the specific written approval of the planning agency designated in section 314(a) of the Public Health Service Act (and, where it exists, the agency designated in section 314(b) of such Act).

"(d) Where any person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would be excluded in determining Federal payments under the program involved if the person had acquired it by purchase, the Board shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V and XX with respect to services furnished in such facility, deduct the amount which in its judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital, deduct any amount deposited under the terms of the lease or comparable arrangement.

"(e) Any person dissatisfied with a determination by the Board under this section may, within four months following notification of such determination, request the Board to reconsider such determination. A determination by the Board under this section shall not be subject to administrative or judicial review.

"(f) For the purposes of this section, a capital expenditure is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which each expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

"(g) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts."

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 303. Section 201(g)(1) of the Social Security Act is amended by striking out "Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII" in subparagraph (A) and inserting in lieu thereof "National Health Care Trust Fund established by title XVIII;"

ADDITIONAL TECHNICAL AND CONFORMING AMENDMENTS AND TRANSITIONAL PROVISIONS

SEC. 304. The Board of the Social Security Administration shall, as soon as practicable but in any event not later than July 1, 1976, after the date of the enactment of this

Act, submit to the Senate and the House of Representatives a draft of any technical and conforming changes in the Social Security Act and other laws which are necessary to reflect the changes in substantive provisions of law made by this Act, including any special provisions which may be necessary to assure an orderly transition from existing programs to the new or modified programs established by this Act.

EFFECTIVE DATE

SEC. 305. Except as specifically otherwise indicated, this Act and the amendments made by this Act shall take effect October 1, 1977.

94TH CONGRESS
1ST SESSION

S. 2644

IN THE SENATE OF THE UNITED STATES

NOVEMBER 11, 1975

Mr. FANNIN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act to require employers to make an approved health care plan available to their employees, to provide a health insurance plan for low-income persons, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Health Standards Act".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds that—

(1) the health of the Nation's people is fundamental to their well-being and the Nation's productivity;

(2) every citizen of the Nation should have access to

quality health care and each shares the responsibility for protecting his own health and well-being;

(3) not all of the Nation's people have the ability to purchase quality health care when and where they need it and at a cost they can afford;

(4) the Nation needs to improve and expand its health care system using the existing system as a base upon which to build; and

(5) an improved and expanded health care system should draw from the collective competence and experience of the medical and allied health professions, private enterprise, government, and consumers.

(b) The purpose of this Act is to establish a national health care insurance system that would provide quality health care for all of the Nation's people in accordance with the following principles:

(1) employers would be required to purchase a health care plan for their employees;

(2) Federal Government would assume the total cost of purchasing a health care plan for those unable to pay for their own; and

(3) medicare program would continue to provide medical care for the aged and disabled.

TITLE I—HEALTH BENEFITS FOR EMPLOYEES

Sec. 101. The Social Security Act is amended by inserting immediately after title V thereof the following new title:

“TITLE VI—HEALTH BENEFITS FOR EMPLOYEES

“Sec. 601. Definitions.
“Sec. 602. Health care plan required.
“Sec. 603. Effective date for providing health care plan.
“Sec. 604. Termination of health care plan.
“Sec. 605. Health care plan benefits.
“Sec. 606. Exclusions.
“Sec. 607. Deductibles.
“Sec. 608. Penalties for noncompliance.
“Sec. 609. Additional requirements of health care plans.
“Sec. 610. Approval of plans.
“Sec. 611. Plans for the self-employed and small employer.
“Sec. 612. Regulations of the Secretary.
“Sec. 613. Benefit value equivalency.
“Sec. 614. Employee option.

“DEFINITIONS

“Sec. 601. (a) For the purposes of this title—

“(1) The term ‘employee’ means, with respect to any employer, any individual not eligible for benefits under title XVIII who has been employed by that employer for more than 31 days and either—

“(A) is considered to be a full-time employee; or

“(B) is not considered to be a full-time employee, but who is expected to work at least 20 hours a week for at least 26 weeks during the next 12 months; or

“(C) is not considered to be a full-time employee, but who has actually worked at least 20 hours a week for at least 26 weeks during the previous 12 months.

"(2) The term 'employer' means an individual, firm, or agency that employs at least one employee as defined by this title.

"(3) The term 'approved health care plan' means a plan of employee health benefits which—

"(A) must be in writing;

"(B) must be adopted by the employer;

"(C) must be communicated by the employer to his employees;

"(D) must provide at least the benefits described in this title; and

"(E) must cover each employee, employee's spouse, and employee's dependent unmarried children under age 21, or, if the dependent child is a full-time student, under age 23. If an employee's dependent child incurs a covered illness or disability while eligible for benefits described in this title, the eligibility of such child shall remain in effect as defined in section 1614 (a) of the Social Security Act.

"(4) The term 'benefit value equivalent' means that the total expected claim cost per employee of the equivalent health insurance plan shall be at least equal to the total expected claim cost of the benefits described in section 605 including 100 percent of the expected claim cost of each of the benefits described in sections 605(a)(1), 605(a)(2), and 605(a)(3).

"(5) The term 'physician' means a doctor of medicine, doctor of osteopathy, doctor of podiatry, and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry.

"(6) The term 'inpatient hospital services' means all inpatient services customarily furnished and charged for by a hospital, except for convenience items such as telephone and television, including (but not limited to)—

"(A) bed and board;

"(B) such physicians' services in the hospital (such as those of radiologists and pathologists) as are held out as generally available to all patients of a hospital;

"(C) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients; and

"(D) such other diagnostic or therapeutic items or services, furnished by the hospital, as are ordinarily so furnished to inpatients of the hospital.

"(7) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls.

"(8) The term 'skilled nursing services' means services and items specified as such in regulations of the Secretary including the services specified in section 1861 (h).

"(9) The term 'skilled nursing home' means those facilities which meet the requirements of paragraphs (1) through (9) of section 1861 (j).

"(10) The term 'hospital' shall have the same meaning as when used in title XVIII.

"(11) The term 'carrier' means an insurance company, a hospital service or hospital expense indemnity organization, a medical service or medical expense indemnity organization, a dental service or dental expense indemnity organization, a fraternal benefit society, an employer who makes available directly to his employees a health care plan or other similar organization, society, or funding arrangement which provides coverage for health care.

"(12) The term 'ambulance services' means those services customarily provided and charged for by a medical service transportation company or other organization providing transportation for individuals who are ill or disabled but only when such services are medically necessary as delineated in regulation promulgated by the Secretary.

"(13) The term 'qualified health maintenance organization' means a health maintenance organization, as defined in section 1301 of the Public Health Service Act, which has been certified by the Secretary as capable of providing health services to its members in the manner prescribed by this title and that it is organized and operated in the manner prescribed by section 1301 (c) of the Public Health Service Act.

"(14) The term 'exclusions' means an expense incurred for items or services described in section 606 for which no payments need be made under this title.

"(15) The term 'deductibles and coinsurance' means those costs which must be borne by an individual or family for services and items described in section 607.

"HEALTH CARE PLAN REQUIRED

"SEC. 602. (a) Every employer, other than one excluded by subsection (b), shall provide his United States resident employees (and the members of their families) an approved health care plan. With respect to United States citizen employees performing services outside the United States, variations, as determined by the employer, in the provisions of an approved health care plan may be permitted.

"(b) The provisions of subsection (a) shall not apply to a foreign government or an international organization described in section 210(a)(15), or any agency or instrumentality of one or more of the foregoing.

"(c) In the case of any employer who, on the date of enactment of this title is a party to a contract with all or some of his employees (or any labor union or other association representing all or some of his employees) which (1) includes provision for coverage under a health care plan, and (2) is still in effect on the effective date of this title, the provisions of subsection (a) shall not, until the expiration, of such contract, apply with respect to any of such employees to whom coverage under such health care plan is made available.

"(d) For the purposes of this section an employer shall meet the requirements of subsection (a) in any case where he pays not less than 50 per centum of the cost of providing such plan for his employees; and is hereby authorized to deduct any cost contribution from such employee(s) pay.

"EFFECTIVE DATE FOR PROVIDING HEALTH CARE PLAN

"SEC. 603. Every employer covered under this title shall provide an approved health care for his employees (and the members of their families) beginning one year after the date of enactment of this title.

"TERMINATION OF HEALTH CARE BENEFITS

"SEC. 604. In the case of any employee who has coverage under a health care plan required by this title, such coverage shall be maintained in effect for a period of 31 days following termination of the employment relationship with his employer if the covered employee (or his surviving spouse) so chooses.

"HEALTH CARE PLAN BENEFITS

"SEC. 605. (a) An approved health care plan shall subject to the provisions of section 612, provide payment for the following services, prescribed by a physician, in each benefit period for each covered member—

"(1) inpatient hospital services;

"(2) physician services and any medical supplies customarily furnished by physicians as part of such services which are furnished:

"(A) while the covered person is an inpatient in a hospital, or

"(B) in connection with a surgical procedure performed while the covered person is not an inpatient in a hospital;

"(3) X-ray and laboratory services provided on an outpatient basis (including radiation therapy);

"(4) outpatient physician professional services (other than those of the types specified in other items of this section).

"(5) drugs requiring the prescription of a physician licensed to prescribe drugs;

"(6) services of a physical therapist provided on an outpatient basis;

"(7) psychiatric care, limited to two visits a week, provided on an outpatient basis;

"(8) extended care services furnished an individual after transfer from a hospital in which he was an outpatient for not less than 3 consecutive days;

"(9) medical devices and prostheses;

"(10) durable medical equipment that has no normal personal use in the absence of the condition for which prescribed, and

"(11) ambulance services.

"(b) Payments made for psychiatric care under paragraph (7) of subsection (a) shall not exceed $20 per visit per person, provided on an outpatient basis.

"(c) (1) The benefits described in paragraphs (1), (2), and (3) of subsection (a) shall be available to employees not later than 1 year after the date of enactment of this section.

"(2) The benefits described in paragraphs (4), (5), (6), (7), (8), (9), (10), and (11) of subsection (a) shall be available to employees not later than 5 years after the date of enactment of this section.

"EXCLUSIONS

"SEC. 606. (a) No payment need be made for coverage of any expenses incurred for items or services—

"(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

"(2) for which the individual furnished such items has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(3) which are paid for directly or indirectly by a governmental entity (other than under this title);

"(4) which constitute personal comfort items;

"(5) where such expenses are for eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses;

"(6) where such expenses are for orthopedic shoes;

"(7) where such services are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

"(8) where such expenses are for custodial care;

"(9) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth except that payment may be made for inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization;

"(10) where such expenses are for the treatment of flat foot conditions, or routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygiene care);

"(11) where such expenses are for the purchase, rental, or repair of hearing aids;

"(12) where such expenses are for—

"(A) private room accommodations provided during inpatient hospital confinement unless such accommodations are medically necessary; or

"(B) private duty nursing;

"(13) where such expenses are for general physical examinations or immunizations;

"(14) where such expenses are for services received prior to the effective date of coverage; or

"(15) where such expenses are for the cost of the first three pints of whole blood (or equivalent quantity of packed red blood cells as defined by regulations) furnished during any spell of illness.

"(b) An approved health plan may also exclude from coverage payments with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations to be promulgated by the Secretary), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State.

"DEDUCTIBLES AND COINSURANCE

"SEC. 607. (a) With respect to the services described in section 605 (other than obstetrical care), an approved health care plan must provide that an eligible individual or family will be required to pay for not more than the following—

"(1) for any calendar year, $100 for each individual for covered charges not to exceed $200 per family, and

"(2) 25 per centum of the next $10,000 of covered charges incurred in any calendar year except that this subclause (2) shall not apply to the services described in subsection 605(a)(7); or

"(3) with respect to the services described in subsection 605(a)(7), 50 per centum of the next $10,000 of covered charges incurred in any calendar year provided the plan payment for such charges does not exceed $20 per visit.

"(b) With respect to obstetrical care provided under this title, the health care plan will pay 50 per centum of charges up to a maximum of $500 for any one pregnancy.

"PENALTIES FOR NONCOMPLIANCE

"SEC. 608. (a) In any case in which the appropriate State official has found, after notice and opportunity for a hearing to the employer, that the employer is not making available to his employees a health care plan which complies with the requirements of this title, he may, after making such efforts as he finds appropriate to secure the employer's voluntary compliance with this title, request the State's Attorney General to bring suit in the district in which the employer designates as his principal place of business, to compel the employer to comply with the provisions of this title.

"(b) Any employer who willfully and knowingly fails to adopt an approved health care plan as required under this title—

"(1) may be assessed a civil penalty of not more than two times that amount such an employer would have spent, in any period not longer than the most recent 24-month period, had such employer complied with the requirements of this title; and

"(2) shall reimburse all employees for actual expenditures for health care, made within 24 months of the date the expense occurred, that would have been reimbursed by an approved health plan had the employer been in compliance with this title.

"ADDITIONAL REQUIREMENTS OF HEALTH CARE PLANS

"SEC. 609. A health care plan, to be approved by the appropriate State official as required by this title, must provide that—

"(1) each hospital or other facility providing care on an inpatient basis shall, in order to be eligible for reimbursement—

"(A) have in effect a utilization review plan which meets the requirements imposed by sections 1155(a)(1)(A), 1155(a)(1)(B), and 1155(a)(1)(C);

"(B) accept reimbursement on the basis of prospective budgets with payments based on uniform rates for all patients for a fixed period of time and such rates may not include any allowance for costs directly related to facilities or services that are determined by the appropriate health planning agency to be inconsistent with State or local health needs;

"(C) be reviewed periodically by a group representative of public and private payors who will analyze the services provided, financial statements, statistics, operating and capital budgets and other pertinent data;

(D) submit to the appropriate health planning agency all proposed capital expenditures which exceed $100,000, change the facility's bed capacity or substantially change the facility's services; and

"(2) each physician providing services under this title shall, in order to be eligible for reimbursement—

"(A) agree that his services may be reviewed by a utilization review committee established pursuant to part B of title XI; and

"(B) accept reimbursement on the basis of usual and customary charges.

“APPROVAL OF PLANS

“SEC. 610. (a) Each carrier which develops and offers a health care plan to any employer to whom section 602 (a) is applicable shall notify the appropriate State official within 30 days after such employer subscribes to a health care plan.

“(b) In the case of any employer who does not enter into arrangements with an insurance company or other such organization but instead makes available directly to his employees a health care plan, such employer shall so notify the appropriate State official and provide information concerning the contents of the plan. Such employer shall notify the appropriate State official within 30 days after the development and implementation of the plan.

“(c) If the appropriate State official, after reviewing the contents of a health care plan required by this title, finds that a plan complies with the requirements of this title as presented in regulations promulgated by the Secretary, he shall approve the plan and notify the employer.

“PLANS FOR THE SELF-EMPLOYED AND SMALL EMPLOYER

“SEC. 611. (a) Each insurance company or other such organization which develops and offers health care plans to any employers to whom section 602 (a) is applicable, must develop (itself or in combination with other such carriers) a health care plan or plans to which employers with less than one hundred employees and self-employed individuals and other individuals not eligible for benefits under title XX may subscribe.

"(b) It shall not be unlawful under any antitrust law for any carrier to enter into any contract, combination, or other arrangement with any other such carrier after the date of enactment of the title for the sole purpose of establishing or participating in an insurance pool arrangement whereby there will be offered to the public health insurance coverage approved under paragraph (a) of this section.

"REGULATIONS OF THE SECRETARY

"SEC. 612. In addition to regulations specifically required or authorized by this title, the Secretary is authorized to prescribe such further regulations as he deems necessary to the efficient administration of this title.

"BENEFIT VALUE EQUIVALENCY

"SEC. 613. (a) Each employer required by section 602 to provide his employees (and the members of their families) an approved health care plan shall provide a plan which provides payment for all health care benefits described in section 605 or which is the actuarial equivalent (as defined by this title) of the benefits described in section 605.

"(b) An employer desiring to adopt a benefit value equivalent plan shall obtain a certificate that his proposed plan is so equivalent from a member of the American Academy of Actuaries or other actuary designated as qualified for this purpose by a State official responsible for regulating health insurance in the State in which the employer is domiciled and such certificate shall be filed with such State official.

"EMPLOYEE OPTION

"SEC. 614. Each employer which is required by section 602 to provide an approved health care plan for his employees (and members of their families) and which employs an average number of employees of not less than twenty-five shall, in accordance with regulations which the Secretary shall prescribe, offer to his employees (and members of their families) an option of membership in a qualified health maintenance organization as specified by section 1310 of the Public Health Service Act.".

TITLE II—HEALTH BENEFITS FOR LOW-INCOME INDIVIDUALS AND THEIR DEPENDENTS

SEC. 201. The Social Security Act is amended by adding after title XX the following new title:

"TITLE XXI—HEALTH BENEFITS FOR LOW-INCOME INDIVIDUALS AND FAMILIES

"Sec. 2101. Definitions.
"Sec. 2102. Establishments of low-income insurance program.
"Sec. 2103. Eligible beneficiaries.
"Sec. 2104. Payment of premiums.
"Sec. 2105. Federal financing responsibility.
"Sec. 2106. Health care insurance program.
"Sec. 2107. Exclusions.
"Sec. 2108. Deductibles and coinsurance.
"Sec. 2109. Requirements for carriers.
"Sec. 2110. State requirements.
"Sec. 2111. Cost-of-living adjustments.

"DEFINITIONS

"SEC. 2101. (a) For the purposes of this title—

"(1) The term 'low-income individual' means any person whose annual income is not in excess of $2,247.

"(2) The term 'low-income family' means any family which includes two or more members and whose annual family income is not in excess of—

"(A) $2,895 (or, if greater the amount determined under section 2111) in the case of two such members;

"(B) $3,548 (or, if greater, the amount determined under section 2111) in the case of three such members;

"(C) $4,540 (or, if greater, the amount determined under section 2111) in the case of four such members;

"(D) $5,358 (or, if greater, the amount determined under section 2111) in the case of five such members;

"(E) $6,028 (or, if greater, the amount determined under section 2111) in the case of six such members; and

"(F) $7,435 (or, if greater, the amount determined under section 2111) in the case of seven or more such members.

"(3) The term 'dependent beneficiary' means any child or stepchild who is a member of a low-income family and who receives more than 50 per centum of his support from such family and has not attained the age of 21, or, if he is a full-time student, has not attained the age of 23. If a dependent beneficiary incurs a covered illness or disability while eligible for benefits described in this title, the eligibility of such beneficiary shall remain in effect regardless of age but shall remain in effect only during the term of such covered illness or disability.

"(4) The term—

"(A) 'physician',

"(B) 'inpatient hospital services',

"(C) 'physicians' services',

"(D) 'skilled nursing home services',

"(E) 'skilled nursing home',

"(F) 'hospital',

"(G) 'carrier',

"(H) 'ambulance service',

"(i) 'qualified health maintenance organization',

"(J) 'exclusions', and

"(K) 'coinsurance and deductibles',

shall have the same meaning as when used in title VI.

"ESTABLISHMENT OF LOW-INCOME INSURANCE PROGRAM

"SEC. 2102. For the purpose of providing medical and hospital care to individuals and families whose income and resources are insufficient to meet the expenses of necessary medical and hospital services, there is hereby established a program of comprehensive medical and hospital benefits for any eligible beneficiary and his dependents who meet the requirements of section 2103.

"ELIGIBLE BENEFICIARIES

"SEC. 2103. (a) Benefits under this title shall be provided for all persons who are residents of the United States, qualify as a 'low-income individual', 'low-income family', or 'dependent beneficiary' as defined by this title, and files an application under this title (filed in such form and manner and containing such information as the Secretary shall by regulations prescribe).

"(b) An individual or family that is not eligible under subsection (a) may establish eligibility by making appropriate premium payments as required under section 2104 and upon payment of such amounts shall be eligible for all benefits provided under this title.

"PAYMENT OF PREMIUMS

"SEC. 2104. (a) Every individual who is an eligible beneficiary under section 2103(a) shall be eligible to receive full payments of allowable premiums for a health care insurance policy or plan described in section 2106.

"(b) Every individual who wishes to establish eligibility under section 2103 (b) shall be required to contribute toward the cost of the program described in section 2106 an amount limited as follows—

"(1) in the case of an individual or family whose annual income is not in excess of 105 per centum of the amounts described in sections 2101 (a) (1) and 2101 (a) (2), such individual or family shall pay to the administering carrier an amount equal to 10 per centum of the allowable premium;

"(2) in the case of an individual or family whose annual income is in excess of 105 per centum of the amounts described in sections 2101 (a) (1) and 2101 (a) (2), but is not in excess of 110 per centum of such amounts, such individual or family shall pay to the administering carrier an amount equal to 20 per centum of the allowable premium; and

"(3) in the case of an individual or family whose annual income is in excess of 110 per centum of the amounts described in sections 2101 (a) (1) and 2101 (a) (2), but not in excess of 115 per centum of such amounts, such individual or family shall pay to the administering carrier an amount equal to 30 per centum of the allowable premium.

"(4) in the case of an individual or family whose annual income is in excess of 115 per centum of amounts described in sections 2101(a)(1) and 2101(a)(2), but not in excess of 120 per centum of such amounts, such individual or family shall pay to the administering carrier an amount equal to 40 per centum of the allowable premium.

"(5) in the case of an individual or family whose annual income is in excess of 120 per centum of the amounts described in sections 2101(a)(1) and 2101 (a)(2), but not in excess of 125 per centum of such amounts, such individual or family shall pay to the administering carrier an amount equal to 50 per centum of the allowable premium.

"FEDERAL FINANCING RESPONSIBILITY

"SEC. 2105. (a) The Secretary shall pay to each State 100 per centum of the costs necessary to provide medical care benefits to eligible beneficiaries as required under this title.

"(b) There are authorized to be appropriated from time to time to the Secretary sums equal to the costs of providing benefits under this title.

"HEALTH CARE INSURANCE PROGRAM

"SEC. 2106. (a) For the purposes of this title, a health care policy or plan must—

"(1) provide payment for the following services, prescribed by a physician, in each benefit period for each covered member—

"(A) inpatient hospital services;

"(B) physician services and any medical supplies customarily furnished by physicians as part of such services which are furnished while the covered person is an inpatient in a hospital, or in connection with a surgical procedure performed while the covered person is not an inpatient in a hospital;

"(C) X-ray and laboratory services provided on an outpatient basis (including radiation therapy);

"(D) outpatient physician professional services;

"(E) drugs requiring the prescription of a physician licensed to prescribe drugs;

"(F) services of a physical therapist provided on an outpatient basis;

"(G) psychiatric care, limited to two visits a week, $20 per visit, per person, provided on an outpatient basis;

"(H) skilled nursing home services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days;

"(I) medical devices and prostheses;

"(J) durable medical equipment that has no normal use in the absence of the condition for which prescribed; and

"(K) ambulance services.

"(2) assure that payments will be made only to those hospitals or other facilities providing care on an inpatient basis which—

"(A) have in effect a utilization review plan which meets the requirements imposed by sections 1155(a)(1)(A), 1155(a)(1)(B), and 1155(a)(1)(C);

"(B) accepts reimbursement on the basis of prospective budgets with payments based on uniform rates for all patients for a fixed period of time and such rates may not include any allowance for costs directly related to facilities or services that are determined by the appropriate health planning agency to be inconsistent with State or local health needs;

"(C) agrees to be reviewed periodically by a group representative of public and private payors who will analyze the services provided, financial statements, statistics, operating and capital budgets, and other pertinent data; and

"(D) submits to the appropriate health planning agency all proposed capital expenditures which exceed $100,000, change the facility's bed capacity or substantially change the facility's services.

"(3) assure that each physician providing services under this title shall, in order to be eligible for reimbursement—

"(A) agree that his services may be reviewed by a utilization review committee established pursuant to part B of title XI; and

"(B) accept reimbursement on the basis of usual and customary charges.

"EXCLUSIONS

"SEC. 2107. (a) No payment need be made under this title for any expenses incurred for items or services—

"(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

"(2) which constitute personal comfort items;

"(3) where such expenses are for eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses;

"(4) where such expenses are for orthopedic shoes;

"(5) where such services are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of a malformed body member;

"(6) where such services are for custodial care;

"(7) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structure directly supporting teeth except that payment may be made for inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization;

"(8) where such expenses are for the treatment of flat foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygiene care);

"(9) where such expenses are for the purchase, rental, or repair of hearing aids;

"(10) where such expenses are for—

"(A) private room accommodations provided during an inpatient hospital confinement unless such accommodations are medically necessary; or

"(B) private duty nursing;

"(11) where such expenses are for general physical examinations or immunizations;

"(12) where such expenses are for services received prior to the effective date of coverage; or

"(13) where such expenses are for the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished during any spell of illness.

"(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations to be promulgated by the Secretary), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State.

"DEDUCTIBLES AND COINSURANCE

"SEC. 2108. With respect to the services described in section 2106, each beneficiary under this title shall pay for not more than the following—

"(1) 10 per centum of each service not to exceed in the cumulative 5 per centum of annual income, except that this subclause (1) shall not apply to the services in subsection 2106(a)(1)(G), or

"(2) with respect to the services described in subsection 2106(a)(1)(G), payment shall not exceed $20 per visit, per person, provided on an outpatient basis.

"REQUIREMENTS FOR CARRIERS

"Sec. 2109. (a) No private insurance company or other organization shall be utilized in the administration of this title or title VI unless such insurance company or other such organization develops (in combination with other such carriers or other organizations) health care policies which may be purchased for individuals and families under this title.

"(b) It shall not be unlawful under any antitrust law for any carrier to enter into any contract, combination, or other arrangement with any other such carrier after the date of enactment of this title for the sole purpose of establishing or participating in an insurance pool arrangement whereby there will be offered health insurance policies approved under this title.

"STATE REQUIREMENTS

"Sec. 2110. (a) Each State shall receive periodically from the Secretary, and the Secretary shall pay periodically to each State, such funds as are authorized under section 2105.

"(b) Each State shall contract or make other arrangements with a health insurance carrier (or carriers) which shall pay to practitioners, institutions, and other providers, on behalf of the individuals and families required under section 2103 to be made eligible therefor, the costs of providing health care benefits (described in section 2106) in accordance with the provisions of this title.

"(c) The appropriate State agency shall enroll each recipient, required under section 2103 to be made eligible therefor, in the State plan and shall file his application with the administering carrier.

"COST-OF-LIVING ADJUSTMENTS

"SEC. 2111. The Secretary shall, during November of 1977 and of each succeeding year, determine (on the basis of the Consumer Price Index prepared by the Department of Labor for the most recent period prior to July 1976 and the most recent period prior to such November) the per centum of increase (if any) which has occurred in the cost of living since July 1976. If the per centum of increase (rounded to the nearest one-tenth of 1 per centum) is 1 or more per centum under any such determination of the Secretary, then, for the calendar year which commences on January 1 following the November in which the determination is made, each of the dollar amounts set forth in section 2101 (a) (2) (A), (B), (C), (D), (E), and (F) shall, subject to the following sentence, be increased by the same percentage (and rounded, when not a multiple of $1.20, to the next higher multiple of $1.20) as the percentage of such increase (as so rounded). In no event shall the dollar amounts (referred to in the preceding sentence) for the calendar year commencing January 1, 1977, or any succeeding calendar year be less than such amounts as in effect for the preceding calendar year, as determined after application of this section.".

TITLE III—GENERAL PROVISIONS

Sec. 301. Council of health advisers.
Sec. 302. Operation of State benefit pools.
Sec. 303. Quality control.
Sec. 304. Coordination of benefits.
Sec. 305. Severability.
Sec. 306. Effective date.
Sec. 307. Repeal of title XIX.

COUNCIL OF HEALTH ADVISERS

SEC. 301. Title XI of the Social Security Act is amended by adding after section 1131 the following new section:

"COUNCIL OF HEALTH ADVISERS

"SEC. 1132. (a) There is created in the Executive Office of the President a Council of Health Advisers (hereinafter referred to as the 'Council'). The Council shall be composed of seven members who shall be appointed by the President to serve at his pleasure, and with the advice and consent of the Senate. The President shall appoint one member of the Council to serve as Chairman.

"(b) The purpose of the Council is to—

"(1) analyze and interpret trends in the health care field;

"(2) appraise health programs and activities of the Federal Government; and

"(3) appraise the effectiveness of the quality control programs established under this Act.

"(c) The Council is authorized to employ and fix the compensation of such employees, experts, and consultants as is necessary to carry out its functions under this Act.

"(d) The Council shall submit an annual report to the President not later than March 1 of each year. Each such report shall also be transmitted to Congress.

"(e) There are authorized to be appropriated such sums as may be necessary to enable the Council to carry out its functions under this Act.".

OPERATION OF STATE BENEFIT POOLS

Sec. 302. Title XI of the Social Security Act is amended by adding after section 1132 (as added by section 301 of this title) a new section as follows:

"OPERATION OF STATE BENEFIT POOLS

"Sec. 1133. (a) The State insurance pools authorized in title VI and title XXI shall be administered by the administering carrier under regulations promulgated by the appropriate State agency.

"(b) The premiums collected pursuant to title XXI, any service charges paid and the reimbursement for pool losses shall be paid into the pool.

".(c) the pool shall—

"(1) without fiscal year limitation pay all qualified State plan benefit claims certified by the administering carrier;

"(2) without fiscal year limitation pay premiums to approved health maintenance organization (as defined by the Secretary);

"(3) pay the reasonable administrative charges of the administering carrier; and

"(4) pay any other charges for which the pool has a liability.

"(d) The moneys in the pool shall be invested and reinvested in interest-bearing obligations, which may be sold for the purpose of the pool. The interest on, and the proceeds from the sale, of such obligations become a part of the pool.

"(e) An annual experience accounting for the pool for the policy year shall be prepared by the administering carrier and submitted to the Secretary, to the State, and to all carriers participating in the pool.

"(f) All carriers shall participate in any pool losses in accordance with a formula, designed by the administering carrier and approved by the appropriate State official, that equitably allocates pool losses to carriers and approved health maintenance organizations in proportion to their total health care business. For purposes of this subsection the term 'carrier' means an insurance company, a hospital service or hospital expense indemnity organization, a medical service or medical expense indemnity organization, a dental service or dental expense indemnity organization, a fraternal benefit society, or other similar organization, society, or funding arrangement which provides coverage for health care.

"(g) The aggregate pool losses for any policy year to be apportioned among the pool participants shall be limited to 3 per centum of the qualified premiums collected by the pool for the year. Losses in excess of this limitation shall be borne by the Federal Government.

"(h) If the experience accounting reflects a gain for the policy year, such gain shall be retained in the pool and used to minimize future premiums to be paid by the Federal Government.".

QUALITY CONTROL

SEC. 303. (a) The provisions of titles XI and XVIII relating to utilization and professional review and conditions of participation required with respect to providers of health services shall be applicable to all health services provided under this title.

(b) To the maximum extent practicable, the Secretary, in the administration of this title, shall coordinate with the procedures employed in the administration of the health insurance programs established under this Act.

COORDINATION OF BENEFITS

Sec. 304. The approved health care plan must include a provision identical with or substantially similar to the suggest model group antiduplication provision as modified and interpreted in the report of the insurance industry task force on coordination of benefits attached to the report of the C–1 Accident and Health Protection Subcommittee as set forth in volume I of the 1971 proceedings of the National Association of Insurance Commissioners.

SEVERABILITY

Sec. 305. If a provision enacted by this Act is held invalid, all other provisions so enacted shall remain in effect. If a provision enacted by this Act is held invalid in one or more applications, the provision shall remain in effect with respect to all other applications.

EFFECTIVE DATE

Sec. 306. The amendments made by this Act shall become effective on the date of enactment of this Act, except that the provisions of titles VI and XXI of the Social Security Act (as enacted by this Act) shall not become effective until July 1, 1976.

REPEAL OF TITLE XIX

SEC. 307. Title XIX of the Social Security Act is repealed, effective July 1, 1976.

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